An Examination of the Frequency of Dissociation in Traumatic Grief

Geraldine Lum

B. B. Sc., La Trobe University,

M.A. (Pass) University of Sydney

Submitted in fulfilment of the requirements for the Degree of

Master of Psychology (Clinical)

School of Psychology

University of Tasmania

May 2010

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Acknowledgements

The writing and completion of this thesis was made possible with the help of many people who gave generously of their time and effort and who patiently withstood my confusion and despair. Of particular note are Drs. Elaine Jensen, Jan Martin, David Harries and Carmel Lum for giving more than one could ever expect. To these friends and family I hold a deep gratitude for their selflessness and epic staying power over these many years. I would also like to thank my supervisors Drs. Iain Montgomery, Walter Slaghuis and Raimondo Bruno for their contribution to my work and to Douglas McGinn for his clerical assistance. Finally, I owe a quiet thank you to Gumby for sitting patiently at my feet for so many of those years.

Table of Contents

List of Tables

ABSTRACT

The study and treatment of pathological grief occurs in an environment in which there is no agreed set of criteria for pathological grief. The primary aim of this thesis is to determine whether or not a relationship exists between Traumatic Grief (TG), dissociation, and general psychological distress. The purpose of this study is to investigate if dissociation is more frequent in those bereaved that meet criteria for TG compared to those bereaved who do not. It also aims to establish if those bereaved with a history of traumatic life events dissociate more frequently and report greater general psychological distress than those with no history or with a history of lesser stressful life events. Participants who experienced bereavement were recruited from a newspaper article, self help groups, bereavement counselling services and first year psychology lectures. On the basis of their scores on the Inventory of Traumatic Grief and the Posttraumatic Stress Diagnostic Scale, 49 participants were divided into one of three clinical groups labelled Control, PTSD (Posttraumatic Stress Disorder) and TG+PTSD (Traumatic Grief and Posttraumatic Stress Disorder). The frequency of dissociative experiences, level of general psychological distress and degree of traumatic life experiences were measured from their responses to the Dissociative Experiences Scale, the General Health Questionnaire-28 and the Stressful Life Events Screening Questionnaire respectively.

The findings showed that dissociative frequency and general psychological distress were found to be significantly greater in those who met symptom criteria for TG+PTSD. General psychological distress was also found

to be greater in those who only met the symptom criteria for PTSD. No significant differences in the kind and quality of experiences of traumatic life events were found between the clinical groups, although the PTSD group showed a trend towards experiencing a greater severity of traumatic life events than did the Control. It was found that a history of multiple traumatic life events was associated with an increase in dissociative frequency and PTSD symptom severity. No association was found between the number of traumatic life events reported by participants and their level of general psychological distress.

It is concluded that those with TG, when compared with other bereaved persons, have significantly more dissociative experiences. The results also indicate that dissociation and the severity of PTSD symptoms in the bereaved, is associated with a history of multiple, interpersonal traumatic life events. The findings of this thesis suggest that TG and PTSD may stem from the same psychological construct.

1.0.0 Introduction to the thesis

There has been much separate research into both grief and trauma, but few studies have investigated the traumatic aspects of grief. One condition that is known to be associated with traumatic stress responses is dissociation (Horowitz, 1997; Merckelbach & Muris, 2001; Putnam, 1997). This thesis seeks to establish if those suffering from a traumatic form of grief also report a higher incidence of dissociation and general psychological distress, in comparison with those who are not traumatised by their loss. Interest in this research question arose from two observations. The first was that it is frequently reported within the grief literature that numbing is a common aspect of the grief experience, particularly in the early stages of grief. The second observation was that it is frequently reported in the trauma literature that dissociation appears to be linked to the experience of being overwhelmed by a traumatic experience, and further, that this can occur at the time of a traumatic event. These two observations lead to the question of whether these responses to the overwhelming experiences of numbing and dissociation may be similar or even related since both are part of a sequela that follows from an extremely distressing experience. Given that numbing is a recognised aspect of grief (McKissock & McKissock, 1995; Prigerson et al., 2000; Raphael & Martinek, 1997; Regehr & Sussman, 2004) it was proposed that where the bereavement and grief experience is extreme, dissociation might also be expected to be an aspect of the grief response. If this is correct, then this will have bearing on the implications of psychological treatment for those bereaved as dissociation interferes with associative processes in the integration of information and experiences (Putnam, 1997). Dissociation in grief therefore became the focus

of investigation and the aim of this thesis is to establish if dissociation is associated with a traumatic form of grief. It attempts to investigate this by taking Traumatic Grief (TG), a construct proposed by Prigerson, Shear et al. (1999), and applying a widely used measure of dissociation, the Dissociative Experiences Scale, (E. B Carlson & Putnam, 1993), to establish if there is an association between TG and dissociation. Numbing itself is not explored because numbing is neither an interest of this investigation nor is it an area that is sufficiently defined to add clarity.

The thesis is structured in the following way: Chapter 1 provides background to the area of investigation by explaining the constructs related to the research question such as trauma, grief, TG and dissociation. It commences with a definition of a traumatic event and introduces the measures used to investigate TG, dissociation, general psychological distress and traumatic life events. Following this, the chapter then focuses on the definitions of grief and dissociation and discusses the concept of TG (Prigerson et al., 1999), a construct of grief pathology that considers the traumatic nature of the symptoms. The possible presence of dissociation in grief is also raised and is followed by a review of the findings concerning dissociation in the grief and trauma literature.

Chapter 2 explores the inter-linkages between the key constructs. A particular focus is the lack of agreed definition of pathological grief. This is followed by a discussion of more recent developments in grief pathology, in particular, Complicated Grief Disorder by Horowitz et al. (1997) and TG by Prigerson, Shear, et al. (1999). The subsequent section examines the controversy around the broadening of Criterion A1 in the Diagnostic and

Statistical Manual-IV (DSM-IV) (American Psychiatric Association, 2000) for PTSD. The review ends by noting that to date there have been no empirical examinations of the presence of dissociation in grief.

Chapter 3 provides specific details of the research methodology. An explanation is given of the three clinical groups in which the participants fell and their reclassification into five different traumatic life event categories. Following this, the materials employed and the investigative procedure adopted are introduced. The final section concludes with an explanation of the statistical analyses performed, the results of which are reported in the following chapter.

Chapter 4 explains the results of this investigation. The final chapter, Chapter 5, presents the key findings and conclusions. This chapter discusses the methodological concerns and implications of the findings, and presents the conclusions about how TG and dissociation maybe related.

1.1.0 Trauma

1.1.1 Defining a traumatic event

In the DSM-IV (American Psychiatric Association, 2000), trauma is restricted to an event that involves perceived or actual threat and elicits extreme emotional responses, such as horror, helplessness or terror. Changes to Criterion A1 in the DSM-IV have seen the inclusion of the learning of the unexpected or violent death of a family member or other close associate. The International Classification of Diseases, 10th Revision (World Health Organization, 1992) considers events to be traumatic for individuals when the

events are perceived as threatening or catastrophic and would generally cause distress to virtually everyone. In short, trauma is an experience of extremely distressing magnitude that causes severe emotional shock, sometimes having long lasting psychological effects. For some, the death of someone to whom they are strongly attached is a traumatic experience of an extreme magnitude, such that the loss itself becomes a traumatic event.

1.1.2 Physiology of a stress response

When exposed to a traumatic event the body becomes acutely stressed and this triggers the sympathetic nervous system to release epinephrine and norepinephrine. This subsequently raises the heart rate, blood flow and blood sugar levels, all of which facilitate a rapid response to a stressful situation (N. R. Carlson, Buskist, & Martin, 2000). The hypothalamic-pituitary-adrenocortical axis is activated at these times and there is an increase in corticotrophin releasing factor from the hypothalamus that, in turn, stimulates the pituitary gland's release of adrenocorticotrophin hormone and stimulates the release of cortisol from the adrenal gland (LeDoux, 1998). This increases glucose metabolism. In situations where quick reactions to danger are necessary, this process enables the body to gain access to blood sugar and quickly metabolise it, which is an adaptive response (N. R. Carlson et al., 2000; van der Kolk & McFarlane, 1996). In situations of chronic stress, however, this is postulated to result in damage to the brain, particularly to the hippocampus where there are larger numbers of cortisol receptors (Diamond & Rose, 1994; Sapolsky, 1996).

1.1.3 A measure of traumatic life events

Many measures and studies of posttraumatic stress fail to take into consideration the incidence of multiple traumatic events. There is evidence to suggest that multiple exposures to traumatic events, especially those involving threat or harm from another person to oneself, is highly associated with trauma related symptoms (Green et al., 2000). The Stressful Life Events Screening Questionnaire (Goodman, Corcoran, Turner, Yuan, & Green, 1998) is a measure of traumatic event exposure that assesses both the type and number of traumatic events experienced by the respondents. Although it screens for major disasters, most of the questions in the questionnaire concern traumatic events of an interpersonal nature. It is intended to comprehensively cover all Criterion A1 listed events.

1.1.4 Posttraumatic Stress Disorder (PTSD) and its symptoms

Posttraumatic Stress Disorder (PTSD) is an anxiety disorder but, unlike many other anxiety disorders, a diagnosis of PTSD requires exposure to an event that causes reactions of intense fear, helplessness or horror. It is characterised by the three key features that are hallmarks of a stress response syndrome: that of avoidance, intrusion and elevated levels of arousal (American Psychiatric Association, 2000). Avoidance is the intentional or non-intentional evasion of feelings and thoughts associated with a traumatic event and reminders of the event, and includes numbing, emotional detachment, inability to experience pleasure and a general withdrawal from life and activities (American Psychiatric Association, 2000). Intrusion can occur in the form of re-experiencing the trauma through intrusive and distressing memories

or dreams of the traumatic event. These can be accompanied by reactions of intense physiological arousal and prolonged distress as seen in irritability, sudden bursts of anger, sleep disturbances, hyper-vigilance, exaggerated startle response, concentration and memory difficulties (American Psychiatric Association, 2000).

There is evidence to suggest that dissociation resulting from a disaster, and posttraumatic stress symptomatology are significantly correlated (Bremner, 2005; Koopman, Classen, & Spiegel, 1994; Spiegel, Koopman, Cardena, & Classen, 1996). Dissociation can be, and PTSD is, the result of a traumatic event. Dissociation at the time of the event has been found to be a predictor of later onset PTSD (Marmar, Weiss, & Metzler, 1998; Spiegel et al., 1996).

1.1.5 Measures of Posttraumatic Stress Disorder (PTSD)

There are several measures of PTSD, most of which are administered by a structured clinical interview. However, a few, such as the Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1996), are self-administered and correspond directly to the criteria for PTSD in the DSM- IV (American Psychiatric Association, 2000). These self-administered measures have the benefit of ease of administration but are considered to best serve as screening tools for the disorder (Foa, Cashman, Jaycox, & Perry, 1997). There are other self-administered measures of symptoms of PTSD that report high test-retest reliability and internal consistency, such as the Impact of Event Scale (Horowitz, Wilner, & Alvarez, 1979) and the Minnesota Multiphasic Personality Inventory (Butcher, Dahlstom, Graham, Tellegen, & Kaemmer, 1989). However, having been developed prior to the inclusion of PTSD in the

DSM they fail to correspond to the criteria for PTSD in the DSM-III-R (American Psychiatric Association, 1987) and IV (American Psychiatric Association, 2000). The Posttraumatic Stress Diagnostic Scale provides an indicator of both the severity and the extent of PTSD symptoms, giving it the added advantage of providing more detailed information. The questions are also closely aligned to criteria for PTSD in the DSM-IV (American Psychiatric Association, 2000). In short, measures of PTSD that are self-administered have limitations in that they are not diagnostic tools. This is compounded by the fact that, with the exception of the Posttraumatic Stress Diagnostic Scale, most do not correspond to the DSM-IV criteria for PTSD.

1.1.6 Measures of general psychological distress

Exposure to traumatic events may precipitate a number of other psychiatric symptoms, such as depression and anxiety, and result in a lower level of function and higher level of general distress. The value of obtaining a measure of psychiatric symptoms is that it provides information about the degree of general mental health function in the respondents. The General Health Questionnaire is a measure that differentiates between those with good and those with poor general, mental health function. In particular, it covers the symptoms of depression, anxiety, somatic complaints and social function, both in terms of an inability to function as one normally would and in terms of recent onset of symptoms. In measuring general psychiatric health, the General Health Questionnaire provides an overall picture of the level of function and distress being experienced. However, it is not a perfect measure in that it seeks only changes in function and symptomology that have taken place in recent weeks, and if poor function and symptomology are 'no more than usual' or

'same as usual', the chronicity of the respondent's condition may not be evident (Goodchild & Duncan-Jones, 1985). This can be partially overcome by scoring the responses using a Likert Scale which produces less skew in the distribution of scores (Goldberg & Williams, 1991). Having explained the key aspects of trauma the next section discusses the experience of grief and the possible linkages between grief and trauma.

1.2.0 Grief

1.2.1 Defining Grief

Whilst trauma is not considered a natural experience of life, grief is. Grief, bereavement and mourning are understood as experiences of loss. Grief is an intense emotional reaction to the profound loss of someone or something to whom or to which one is emotionally attached. Bereavement is the state of being that results from the death of a loved one (Cook & Oltjenbruns, 1989) and mourning is the observable expression of grief (Parkes & Weiss, 1983).

Grief is accompanied by a wide range of emotions, cognitions, and physical sensations. Common emotional reactions are sadness, anger, guilt, anxiety, loneliness, fatigue, helplessness, shock, yearning, relief and numbness (Worden, 1991). Cognitive states such as disbelief, depersonalisation, confusion, preoccupation and a sense of the presence and/or hallucinations of the deceased are typically reported after a death. Physical sensations reported by those in grief have been hollowness in the stomach, tightness in the chest and throat, over-sensitivity to noise, breathlessness, weakness in the muscles and a lack of energy. The range of sensations in grief are far ranging and

according to Worden (1991) "there is nothing pathological about any one of them. However, feelings that exist for abnormally long periods of time and at excessive intensity may portend a complicated grief reaction" (p. 25).

1.2.2 Phases of Grief

Most of the research on the progression of grief describes it as having an initial reaction, primarily of shock, disbelief and numbness. This is followed by intense emotions, social and personal withdrawal and, at times, somatic complaints. Gradually a reduction of physical and emotional symptoms occurs together with a resumption of personal and social functioning (Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992). These processes can be seen in a succession of reactions that move through phases of numbing, yearning, searching, disorganisation or despair and reorganisation (Bowlby, 1980; Parkes, 1970). These phases are not conceived of as rigid stages but may overlap and the bereaved will often move from one stage to another only to return to a former phase. In brief, these are as fluid periods in which the bereaved move to and fro over time with a lessening of time spent in any one phase as one recovers.

1.2.3 Duration and progression of grief

There are many factors that affect grief. Some of these are age, relationship with the deceased, suddenness and possible prevention of the death, sex, cultural background, personality characteristics and coping strategies of the bereaved (Cook & Oltjenbruns, 1989). Each one of these will have an effect on the grief process and duration. Erich Lindemann (1944) found that a timeframe of four to six weeks was sufficient to manage

uncomplicated and undistorted grief reactions in his bereaved population. Contrary to this, however, McKissock & McKissock (1995), suggest that four to six weeks after the death is often when people feel worse. Extending the timeframe even further, M. Stroebe, Hansson, et al. (2001) maintain that the duration of grief in which most people will adapt is a period of one to two years, but that for most people this adaptation is a case of becoming used to the loss rather than getting over it. Jacobs (1993) proposes that the psychological distress experienced in grief has multiple dimensions, commencing with numbness and disbelief in the first month. This subsides with the rise in separation distress. Accompanying these two dimensions are depression and mourning which peak around the fourth month before there begins a gradual decline in intensity. It can be seen from the lack of specificity in the literature regarding the typical time span of the progression of grief, that it appears that a normal progression is defined by a continued lessening of intensity of distress accompanied with a gradual increase in the ability to function and adapt to a world without the deceased, spanning from months to approximately two years.

1.2.4 Grief that fails to adapt

Research on bereavement indicates that for some the effect of loss on their health is detrimental and results in higher levels of illness and mortality (Cleiren, 1993). For example, some may suffer depression or complaints of a somatic nature (W. Stroebe, Stroebe, & Domittner, 1988), which have been shown to be associated with a greater risk of dying (Goldman, Korenman, & Weinstein, 1995; M. Stroebe & Stroebe, 1983).

For those who fail to adapt to their loss, the intensity and duration of grief may be more excessive, seeming to fail to diminish over time, with symptoms being more akin to a traumatic stress response. In these instances traumatic responses such as vigilance, withdrawal, recurrent nightmares, hyper-arousal, helplessness and the shattering of a world assumed to be safe are reported to be not unusual in the bereaved (Cleiren, 1993; Parkes, 2001; Sprang & McNeil, 1995). Unlike "normal" grief, these traumatic responses do not shift readily and over time may be considered pathological. Estimates of the occurrence of pathological grief range from 10-15% (M. Stroebe, Schut, & Finkenauer, 2001) to 20% (Jacobs, Mazure, & Prigerson, 2000). In brief, maladaptive grief is chronic, severe and is often accompanied by some of the same reactions that are seen in traumatic stress responses.

1.2.5 Criteria and symptoms of Traumatic Grief

Traumatic Grief (TG) is a syndrome proposed by Prigerson, Shear et al. (1999) and recommended by Jacobs (2000) for inclusion in the next DSM as an Axis 1 disorder. Jacobs et al. maintain that the word "traumatic" relates to the symptoms of TG and not to the nature of death. They stress that the symptoms relate to the type of symptoms that result from separation from the deceased.

The criteria proposed for TG by Prigerson (2001) are fourfold. The first, Criterion A, concerns the death of a significant other and symptoms relating to the separation distress resulting from the death, symptoms such as distressing and intrusive preoccupation with the deceased in the form of yearning, longing or searching for the deceased. The second, Criterion B, are symptoms indicative of traumatisation by the loss; symptoms such as efforts to

avoid reminders of the deceased, feelings of futility and meaninglessness, numbing or emotional detachment, feeling stunned, dazed or shocked, having difficulty acknowledging the death, feeling that a part of one's self has died, a shattered world view, difficulty imagining a fulfilling life without the deceased, assumed symptoms or harmful behaviours of the deceased, excessive irritability and bitterness or anger at the death. The third criterion, Criterion C, relates to the duration of the symptoms, being that of at least two months. Although this is the minimum duration, Prigerson and Jacobs (2001) state that a minimum of six months gives a greater predictive validity. The fourth criterion, Criterion D, requires that there must be clinically significant impairment in social, occupational or other important areas of functioning. In order to meet criteria for TG, Prigerson and Jacobs (2001) have created the Inventory for Traumatic Grief to facilitate identification of TG with respondents having to meet:

Criterion A1, the death of a significant other,

Criterion A2, three of five symptoms of separation distress,

Criterion B, six of twelve symptoms of traumatic distress,

Criterion C, have experienced the symptoms for two months or more, and

Criterion D, believe that their grief has resulted in significant impairment.

These criteria illustrate the group of symptoms in TG and the nature of distress in those experiencing TG.

1.2.6 Measures of grief

In spite of the number of scales developed to measure grief, apart from the Inventory of Traumatic Grief, many do not provide sufficient psychometric

information (Neimeyer & Hogan, 2001). Some of the better known grief inventories, the Texas Revised Inventory of Grief, the brief Core Bereavement Items and the Grief Experience Questionnaire (Barrett & Scott, 1989) do not provide information regarding test re-test reliability or convergent and discriminant validity. The Texas Revised Inventory of Grief, furthermore includes no details about its construct validity. Despite this lack of psychometric information they continue to be used to measure grief experiences.

The Inventory of Traumatic Grief is a 34-item measure of maladaptive grief. It was designed to distinguish between normal and pathological grief and measures symptoms of traumatic and separation distress, symptoms which are associated with poor bereavement outcomes (Prigerson & Jacobs, 2001). It is a relatively new scale that attempts to measure the construct of TG (Prigerson & Jacobs, 2001) and has been developed from an earlier version of the scale termed the Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995) which is a 19-item scale designed to discriminate between uncomplicated and complicated grief. Internal consistency of the Inventory of Traumatic Grief is high (Cronbach's alpha = .95) and was obtained among a representative sample of 76 elderly widowed residents of Connecticut, on average 3.5 months after the death of their spouse. It has a sensitivity and specificity of 0.93 for both Criteria A2 and B, which are its measure of separation and traumatic distress respectively. Its predecessor, the Inventory of Complicated Grief (Prigerson, Maciejewski et al., 1995) from which many of its questions derive, was concurrently validated against the Beck Depression Inventory (Beck & Steer, 1987), ($r = 0.67$, $p < .001$), the Texas Revised

Inventory of Grief (Faschingbauer, 1981), ($r = 0\ .87$, $p < .001$) and the Grief Measurement Scale (Jacobs et al., 1986), ($r = 0.70$, $p < .001$) and it obtained a test re-test reliability after a period of 6 months of .80. No concurrent validity or test re-test reliability information has been reported for the Inventory of Traumatic Grief. Prigerson and Jacobs (2001) suggest that the Inventory of Traumatic Grief has criterion related validity, as it is significantly associated with the quality of life domains assessed by the Medical Outcomes Survey SF-36 (McHorney, Ware, & Raczek, 1993).

In conclusion, there is little agreed understanding on a complicated course of grief. With the exception of the Inventory of Traumatic Grief, many measures of grief that are available have unknown psychometric properties, but in spite of this continue to be used. Unlike previous conceptualisations of maladaptive grief, TG does not evaluate the circumstances surrounding the death, but instead focuses on symptoms of separation and traumatic distress.

1.2.7 Similarities and differences between Traumatic Grief (TG) and Posttraumatic Stress Disorder (PTSD)

There are many similarities between the traumatic responses of TG and PTSD, with sufficient overlap to argue that TG may be a variant of PTSD (Fox, Reid, Salmon, Mckillop-Duffy, & Doyle, 1999). Similarities include the experience of a specific traumatic event, re-experiencing, avoidance, numbing and arousal. There are also sufficient differences for the proponents of TG to suggest that "although there is substantial overlap of symptoms of TG and those of PTSD, these two disorders do not appear to be isomorphic and TG

may prove to be a unique type of stress response syndrome" (Prigerson & Jacobs, 2001, p. 619).

Whilst many of the symptoms of TG share the same symptoms of PTSD the symptoms are different in their detail. The aetiology of both conditions requires a triggering event, the event in TG being the death of a significant other (Prigerson et al., 2000). In PTSD it is a specified traumatic event (Criterion A1), which may include the death of a significant other, that is experienced with a sense of horror, terror or helplessness (Criterion A2) (American Psychiatric Association, 2000).

Within the symptoms of re-experiencing, avoidance and arousal that are associated with PTSD, there are varying degrees where TG and PTSD overlap. Table 1 below lists the areas of similarity between these two conditions.

Table 1.

Similarities between Traumatic Grief (TG) and Posttraumatic Stress Disorder (PTSD)

Criterion Type	Disorder	Specific criterion
Aetiology	TG	Death of a significant other
	PTSD	Criterion A1 traumatic event with the event experienced with terror, horror or helplessness
Re-experiencing	TG	Intrusive thoughts of the deceased Memories of the deceased being upsetting
	PTSD	Recurrent and intrusive distressing recollections of the traumatic event including images, thoughts or perceptions of the event. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
Avoidance	TG	Avoidance of reminders of the loss of the deceased Subjective sense of numbness, detachment or absence of emotional responsiveness
	PTSD	Diminished interest or participation in significant activities Avoidance of stimuli associated with the trauma Feeling of detachment or estrangement from others Restricted range of affect
Arousal	TG	Excessive irritability, bitterness, or anger related to the death
	PTSD	Irritability or outburst of anger
Duration	TG	At least two months
	PTSD	More than one month

A notable feature of TG, not relevant to PTSD, is the yearning and searching for the deceased. Further differences between the two conditions can be seen in the Item Response Theory analysis on the responses of 76 widowed individuals undertaken by Prigerson et al. (2000). Items of numbness and

shattered worldview were the best indicators of TG whereas avoidance was not an efficient marker of TG. Prigerson et al. noted that their sample fell well below the recommended minimum sample size of 300 respondents and acknowledged that caution must be used when interpreting these results. Fox et al. (1999) suggest that given the overlap between the two disorders, TG might be better classed as a sub-specifier in PTSD rather than as a separate diagnostic category. It is evident that there are areas that both PTSD and TG have in common but there are sufficient differences to argue that they are different syndromes.

Dissociation, like PTSD, is a state that is associated with traumatic stress responses and the next section explains the various manifestations of dissociation, the debate surrounding the nature of its pathology and the measurement of this pathology.

1.3.0 Dissociation

1.3.1 Definition of dissociation

Dissociation is clinically understood to be a "disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment" (American Psychiatric Association, 2000, p. 519) that often involves depersonalisation, derealisation, amnesia, intense absorption, trance states, or the existence of separate sub-personalities. Dissociation can include conversion symptoms (World Health Organization, 1992). Symptoms of dissociation do not occur only in dissociative disorders, they are listed in Acute Stress Disorder, and occur in PTSD and Somatization Disorder (American

Psychiatric Association, 2000). Dissociative symptoms can be transient, as seen in depersonalisation immediately after a traumatic event, and chronic as expressed in dissociative disorders. The term dissociation is broadly used to describe the phenomenon where the process of associative integration of information is disrupted, resulting in a failure to integrate information and experiences (Putnam, 1997).

1.3.2 The Dissociative Experiences Scale

The most commonly used and researched measure of dissociation is the Dissociative Experiences Scale (DES). It measures frequency of dissociative experiences and was designed to be a trait measure of dissociation in clinical populations. Whilst it has been used in non-clinical populations, Carlson and Putnam (1993) warn that this was not its intended purpose because it was designed as a screening tool for dissociative psychopathology and not a diagnostic tool. Furthermore, it has been shown that the factor structure of the Dissociative Experiences Scale varies according to the nature of the population. According to E. B. Carlson & Putnam (1993), non-clinical populations appear to yield a different factor structure with 40% of the variance in scores being the result of items loading on three factors: absorption/changeability, derealisation/depersonalisation and amnestic experiences. In the study by Carlson et al. (1991), 49% of the variance in the psychiatric population appeared to be attributable to factors of amnesia for dissociative experiences, absorption/imaginative involvement and depersonalisation/derealisation. Carlson and Putnam (1993) conclude that the scale can only reliably be said to measure a general dissociation factor rather than any of the components of dissociation. Having explained the state of

dissociation, there seems to be no connection with grief. However, some thanatologists suggest that dissociation is present in some who are grieving.

1.3.3 Dissociation and grief

The presence of dissociation in grief is not an area that has been investigated. Aside from a small number of researchers such as Jacobs (1993) Rando (1993), Kauffman (1993-94), Irwin (1994) and Horowitz (1997), dissociation in grief has not been considered as an aspect of the grief response. Of the few who have reflected on the relationship between dissociation and grief, Jacobs (1993) believes that the severe emotional numbing and disbelief, witnessed in grief, is similar to the dissociative process that occurs in traumatic stress reactions. Similarly, Rando (1993) suggests that numbing experienced in grief is dissociation because it disrupts the normal integration of thoughts, feelings and memories from entering into consciousness. This view is shared by Horowitz (1997) who states that a common stress response to a serious life event, such as the death of a parent, is an unusually heightened state of depersonalisation. Notwithstanding these propositions, almost no research has been undertaken on the occurrence of dissociation in grief. The relationship between dissociation and grief, particularly in maladaptive grief, has yet to be examined.

1.4.0 Summary

There is a lack of specificity with regard to both the intensity and time span of grief symptoms in "normal" grief. Notwithstanding this, there are various constructs of maladaptive grief. Changes to the DSM-IV (American

Psychiatric Association, 2000) have resulted in traumatic events that include the learning of the unexpected or violent death experienced by a family member or other close associate. In accordance with this, it is proposed in this thesis that for some the death of someone, to whom they are emotionally attached, can be an experience of such distressing magnitude that it constitutes a traumatic event.

The proposed syndrome of TG shares some similarities with PTSD but its foci are the traumatic and separation distress experienced by the bereaved. A few researchers have commented on a possible presence of dissociation in grief. However, no empirical studies have been undertaken in the area. Having discussed the basic psychological concepts explored in this thesis, the next chapter looks at the development of our understanding of grief pathology, from its early conceptualisations to more recent attempts to develop a clear definition of two specific forms of grief pathology.

2.0.0 Grief pathology

This chapter provides an examination of the literature on grief and dissociation and is presented in three sections: Grief, Trauma, and Dissociation. The first section discusses the various constructs of pathological grief that have proliferated in the absence of standardised criteria for these constructs, and the benefits that a standardised classification of grief pathology provides. This section is used to demonstrate that, until recently, many of the constructs of grief pathology have been defined on the basis of their deviations from a norm but within a context in which normal grief processes have not yet been defined. The discussion then turns to recent research in grief pathology and two proposed new variants of that pathology, the first by Mardi Horowitz (1997) and the second by Holly Prigerson and her colleagues (1999). These researchers have specified criteria for their versions of grief pathology and this review focuses particularly on the latter's concept of TG. The second section examines trauma and the controversy around the broadening of Criterion A1 for PTSD. Finally, the term dissociation and the problems with the breadth of its definition are explained.

2.0.1 Absence of an agreed definition of pathological grief

The construct of pathological grief has been used and discussed in the grief literature over many years. This construct exists in spite of the fact that grief in its non-pathological state, normal grief, is yet to be validated or operationalised (Middleton, Raphael, Martinek, & Misso, 1993). Furthermore, there are no agreed criteria for defining pathological grief (Jacobs & Kim, 1990; Lindemann, 1944; Middleton, Burnett, Raphael, & Martinek, 1996;

Prigerson et al., 1999). Notwithstanding this, various forms of grief are considered to be pathological. Many of the criteria that have been used to define the different variants of pathological grief concern the intensity or duration of grief and the degree of functional impairment, particularly where these are considered deviations from the normal pattern of grief. Without either normal or pathological grief having been clearly defined, there is little to justify the distinction between these two, especially where there is little supportive empirical evidence to uphold this distinction.

A clear method to delineate pathological from normal grief provides the opportunity to screen the bereaved in need of professional assistance from those who might not derive any benefit from such interventions. This distinction is necessary as some might sustain harm from unwarranted intercession (Schut, Stroebe, van den Bout, & Terheggen, 2001). A distinct method of classifying pathological grief also makes available to those in the mental health and counselling industries a better understanding of the various needs of those bereaved. The ability of these professions to appropriately work with this population is hampered unless the parameters of grief pathology are understood. In order to refine treatments, consensually agreed upon standardised descriptive criteria for grief pathology are necessary so that treatment outcomes can be examined and compared and treatment procedures honed. Without a classification of grief pathology, diagnosticians have only the current diagnostic categories, such as Major Depressive Disorder, Adjustment Disorder, PTSD and Anxiety Disorder to rely on when attempting to classify the various presentations of grief pathology.

2.0.2 Explanations of pathological grief

Some earlier attempts to explain pathological grief have highlighted the circumstances surrounding the death and the relationship with the deceased as contributory causal factors. More recently there have been attempts to delineate pathological grief not only from normal grief but also from other forms of psychiatric illness. Horowitz et al. (1997) proposed a set of criteria that distinguished Complicated Grief Disorder from all other forms of grief, both pathological and normal. This was soon followed by Prigerson et al. (1999) who proposed TG for consideration and study. Unlike previous conceptualisations of pathological grief, both these disorders emphasise the traumatic aspects of grief pathology. In the case of Complicated Grief Disorder, the distress caused by separation from the deceased is said to act as a traumatic stressor (Horowitz, 1997). In TG, the symptoms of re-experiencing and avoidance as seen in numbness and detachment are considered similar to some symptoms of PTSD (Prigerson et al., 2000). For this reason Prigerson et al. (2000) suggest that TG might be appropriately placed within a category of traumatic spectrum disorders.

2.0.3 Development of pathological grief constructs

To date the creation of psychological constructs to differentiate pathological from normal grief, have had little supportive empirical evidence to justify the distinction between these two and have been made without reference to the theoretical issues surrounding the classification and diagnosis of psychiatric conditions (M. Stroebe et al., 2000). It is only in more recent years, as evident in the work of Horowitz et al. (1997) and Prigerson et al. (1999),

that attempts have been made to distinguish pathological grief, not only from normal grief but also from other forms of psychiatric morbidity.

There have been many attempts to describe pathological grief. Early efforts tended to focus on deviations from a normal pattern of grieving. This can be seen in Lindemann's work (Lindemann, 1944) with the bereaved from the Cocoanut Grove Fire from which he concluded that there are two types of morbid grief reactions: *delayed*, where there is an absence of grief that can continue for years, and *distorted,* where there is a distortion of a normal grief reaction, expressed in enduring hostility, agitated depression, social withdrawal and hypochondriacal symptoms.

Another early attempt to explain grief can be observed in Freud's essay "Mourning and Melancholia" (1917) in which he describes normal mourning transforming into pathology when there is ambivalence towards the deceased. This views grief pathology as the outcome of the relationship the bereaved had with the deceased.

Freud and Lindemann's work, heavily cited in the literature, do not stand alone on the subject of grief pathology. Bowlby (1980) saw pathological grief as the result of the intensity of separation distress caused by the death. He proposed that it is the scope and intensity of grieving and its tendency to persist that distinguishes pathological mourning from healthy mourning. Others such as M. Stroebe et al. (2000) suggest that although there is reasonable consensus about grief that has gone on too long, timeframes and intensity levels of a pathological grief response have yet to be verified.

Unlike their earlier counterparts, later authors emphasized the context in which the bereavement occurred as the relevant aspect of pathogenesis. Parkes and Weiss (1983) proposed that the pathological variants of grief are the extreme forms of a normal grief reaction that result from difficult circumstances. The circumstances most likely to give rise to grief pathology, according to Parkes and Weiss (1983), are an unexpected death, or where the relationship the bereaved had with the deceased was extremely troubled, ambivalent or dependent. The view taken here is that the key factors in the development of grief pathology are both the nature of death and the relationship that existed prior to the death.

2.0.4 A brief explanation of Complicated Grief Disorder and Traumatic Grief

Advancing Bowlby's (1980) concept that extreme separation distress is linked with pathological grief, Horowitz et al. (1997) reason that for some, bereavement acts as a stressor that leads to a traumatic stress reaction. This is the basis upon which he proposed Complicated Grief Disorder, the criteria for which are; intrusive symptoms, avoidance symptoms and a failure to adapt to the situation, all of which resemble those for PTSD. The key features of Complicated Grief Disorder, as defined by Horowitz et al. (1997) are intrusive preoccupation with thoughts of the deceased, disbelief, feeling stunned and the inability to accept the death: many of these symptoms being associated with enduring functional impairments. He proposed that the syndrome is of such great intensity that it overwhelms the bereaved, who in turn attempts to control the distress through maladaptive approaches such as numbing and denial.

Developing the impact of loss further, Prigerson et al. (1999) advanced the construct of TG, a stress response syndrome specific to bereavement, the symptoms of which fall into one of two groups, that of separation distress and traumatic distress, detailed in the previous chapter. The word "traumatic" in "Traumatic Grief" refers to the type of symptoms that might be seen in posttraumatic stress syndromes such as PTSD and Acute Stress Disorder, and bears no relationship to the event that gave rise to the disorder. It is their view that the syndrome is an Axis I disorder and needs to be incorporated into the next version of the DSM, the DSM-V.

In summary, normal grief is yet to be clearly defined and pathological grief, as described in the literature appears to have many variants with no agreed criteria for many of the constructs or empirical evidence to support these constructs. It may be concluded that the circumstances surrounding the loss was a defining element in initial conceptualisations of a traumatic grief response, however, in later developments only the traumatic and separation distress symptoms were considered. The more recent conceptualisations of TG and Complicated Grief Disorder have attempted to delineate their constructs of pathology from normal grief, and from other forms of psychiatric disorders.

2.1.0 Trauma

2.1.1 The meaning of trauma

In the literature, the word trauma is used to describe both external traumatic events, such as a motor vehicle accident, earthquake, firestorm, assault, rape and war experience (Briere, Scott, & Weathers, 2005; Clohessy &

Ehlers, 1999; Gold, Marx, Saler-Baillo, & Sloan, 2005) and internal emotional reactions to these events, such as horror or terror (Nijenhuis, Spinhoven, van Dyck, van der Hart, & Vanderlinden, 1998). The dual meaning and usage reflects the two aspects of the first criterion in the DSM-IV, Criterion A1, for PTSD. "The person has been exposed to a traumatic event in which both the following were present: (a) the person experienced, witnessed or was confronted with an event that involved actual or threatened death or serious injury or a threat to the physical integrity to self or others (b) the person's response involved intense fear, helplessness or horror" (American Psychiatric Association, 2000, p. 467). The significance of this is that no external event can be classified as traumatic unless it is experienced as such, that is, with intense fear, helplessness or horror. Van der Kolk and McFarlane (1996) maintain that the critical element of any event that makes it traumatic is the subjective assessment of how threatened and helpless the victim feels. In giving equal importance to both the objective and subjective elements of trauma the DSM-IV (American Psychiatric Association, 2000) recognises that the subjective experience of the event is critical in the evaluation of the experience of a traumatic event.

2.1.2 Traumatic stress response syndromes- a brief history

Although a diagnosis of PTSD was not formulated until 1980 (American Psychiatric Association, 1980), traumatic stress reactions have been recorded since 1920 when Freud (1961) published "Beyond the Pleasure Principle" where he used the term "Traumatic Neurosis" to describe symptoms of trauma. During the Second World War Kardiner (1941) observed that traumatised war veterans appeared to relive the trauma they had previously

experienced. They displayed a persistent sensitivity to being startled and irritated, were inclined to aggressive outbursts, were limited in their personal functioning, and suffered distressing and atypical dreams. Krystal (1988) noted that trauma responses appeared to start with hyper-alert anxiety and progress to a blocking of emotions and inhibition of behaviour. PTSD, Acute Stress Disorder and dissociative disorders are the traumatic stress disorders most closely linked to the experience of a traumatic event. In short, traumatic stress symptoms were identified many decades prior to any traumatic stress syndromes being named and recognised as a distinct disorder.

2.1.3 Posttraumatic Stress Disorder (PTSD) and Criterion A1

PTSD is a stress response syndrome, classified as an anxiety disorder in the DSM-IV, and is characterised by three key features, that of re-experiencing the trauma, avoiding reminders of it and suffering from persistent symptoms of high levels of arousal (American Psychiatric Association, 2000). Unlike other disorders in the DSM-IV (American Psychiatric Association, 2000), the presence of an etiologic event, the range of which is specified in the DSM-IV, is a key element to the diagnosis of PTSD. For a diagnosis of PTSD there must both be exposure to a specified traumatic stressor (Criterion A1) and a specified subjective response to the event, such as intense fear, helplessness, or horror, (Criterion A2). Since the expansion of Criterion A1 to include events that were not in the DSM-III-R (American Psychiatric Association, 1987), including the "learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (American Psychiatric Association, 2000, p. 463), the number of people who have had exposure to a Criterion A1 listed event at some point in

their lives has increased markedly ranging from 56.0% (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995) to 89.6% (Breslau & Kessler, 2001). This latter figure drops to 68.1% when the criterion "learning about unexpected or violent death ..." is removed (Breslau & Kessler, 2001). Commensurate with the increase in exposure to A1 listed events is the rise in the number of diagnosed PTSD cases. It appears that the single event that has had the greatest impact on the increase in the number of PTSD cases is the learning about the sudden, unexpected death of a loved one (Breslau & Kessler, 2001).

The current, broadened range of qualifying Criterion A1 events may still not adequately address responses to other traumatic stressors. Gold et al. (2005) found that, when comparing those who had and had not experienced a Criterion A1 event, out of 800 psychology undergraduate students there were significantly more who reported PTSD type symptoms, on the Posttraumatic Stress Diagnostic Scale (Foa, 1996), without experiencing a Criterion A1 event. They found that the non-Criterion A1 listed events of bereavement (expected), parental divorce, romantic relationship problems and non-life threatening medical problems were the events associated with PTSD symptomatology, with bereavement being the most common event reported. Similarly Mol et al. (2005) in a study of 832 respondents, drawn from several general medical practices, found that those who had experienced a non-Criterion A1 listed event, on average, reported more PTSD symptoms from the non-Criterion A1 event than those whose worst event experienced was a Criterion A1 event. They concluded that PTSD may not be specific to Criterion A1 events and that the relationship between life events, traumatic experiences and general psychological distress is a complex one.

The broadening of Criterion A1 events for a diagnosis of PTSD has created a bracket creep effect (McNally, 2003). With events as diverse as experiencing direct combat to learning about someone else being threatened with serious harm, both considered as potential causal events for the development of PTSD, McNally (2003) suggests that it would be difficult to identify common psychobiologic mechanisms that underlie the symptoms of PTSD. "No longer must one be the direct (or even) vicarious recipient of trauma; merely being horrified by what has happened to others now counts as a PTSD qualifying event" (McNally, 2003, p.231).

The findings of Mol et al. (2005) and Gold et al. (2005), although drawn from large, albeit select populations, indicate that it may be possible to develop PTSD symptoms without having experienced a DSM-IV (American Psychiatric Association, 2000), Criterion A1 event. This posits, first, that the most salient aspect of any event that makes it a traumatic event is the subjective experience of it and, second, it is this subjective experience that is critical in the development of PTSD. The findings of Mol et al. and Gold et al. indicate that perhaps there are more routes to PTSD than are currently known.

In brief, since the expansion of the number of Criterion A1 listed events there has been a substantial increase in the number of PTSD cases. The single event that appears to have had the greatest impact on the increased number of cases is the learning about the sudden, unexpected death of a loved one. Considering that the DSM-IV (American Psychiatric Association, 2000) now includes this as a Criterion A1 listed traumatic event, and that dissociation is a feature of PTSD, then dissociation in bereavement becomes an obvious area of possible connection.

2.2.0 Dissociation

2.2.1 Pathological and non-pathological dissociation

Dissociation occurs in the general population and having dissociative experiences is not necessarily pathological (Putnam et al., 1996; Ray, 1996; Ross, Joshi, & Currie, 1990). The term "dissociation" is inclusive of a broad range of symptoms extending from high levels of absorption to extreme states of altered consciousness. Some dissociative symptoms, such as absorption, are considered within the realm of normal processes whilst others are viewed as pathological. It is argued that pathology lies in the type and frequency of the dissociative experience (Putnam et al., 1996; Waller & Ross, 1997; West, 1967). Ross et al. (1990) found that the mean score for dissociative experiences, as measured by the Dissociative Experiences Scale, in a population of 1055 persons in Canada was 10.8. To give some context to this, scores of 20 or above are potentially worthy of further clinical investigation (E. B Carlson & Putnam, 1993).

The symptoms of dissociation are many and varied. They can be perceptual, emotional, cognitive or functional. They can involve altered perception of time, space, sense of self and reality. They can vary from anaesthesia to analgesia to intolerable pain. At an emotional level, dissociative states can encompass hyper-aroused states such as panic, and hypo-aroused states such as emotional numbing (Nijenhuis et al., 1998; Spiegel, 1997). Motor disturbances may be observed in physical weakness, paralysis, tremors or convulsions (American Psychiatric Association, 2000). Cognitive symptoms might display as confusion, dysphasia, dyscalculia, or severe attentional

deficits (Putnam, 1997). There can also be memory disturbances where images or feelings from the past suddenly recur in flashbacks, where an individual wanders off in fugue states because of a loss of memory of the current environment, or where the individual cannot recall the traumatic event (Scaer, 2001). Additional to this, dissociation also describes specific disruptions in consciousness, seen in separate sub-personalities, as well as disruptions in one's experience of self and the environment, described as depersonalisation and derealisation respectively (American Psychiatric Association, 2000).

Further to this, on the basis of three taxometric analyses of responses on the Dissociative Experiences Scale, from 228 cases of Multiple Personality Disorder subjects and 228 cases of normal controls, Waller et al. (1996) proposed that there are two kinds of dissociative phenomena, pathological and non-pathological. Pathological dissociation is considered as distinct and discrete dissociative states that include derealisation, depersonalisation, identity alteration and amnesia for previous states of dissociation; and non-pathological dissociation is considered to be a dimensional construct that ranges along a continuum of greater or lesser degrees of dissociation.

2.2.2 Peritraumatic dissociation

The term dissociation is not limited to chronic dissociative conditions, it is used to describe transient states of dissociation, such as peritraumatic dissociation (Bremner, Vertmetten, Southwick, Krystal, & Charney, 1998). Peritraumatic dissociation is an immediate response to a traumatic event that occurs during or soon after the traumatic event. More recent studies have suggested that it is persistent or chronic dissociation rather than peritraumatic

dissociation that leads to psychopathology (Briere et al., 2005; McFarlane, 1997; Murray, Ehlers, & Mayou, 2002).

Dissociation has been shown to be significantly correlated with indices of traumatic severity (Cardena & Spiegel, 1993; Chu & Dill, 1990; Kirby, Chu, & Dill, 1993; Maercker, Beauducel, & Schutzwohl, 2000) with magnitudes ranging from Pearson's $r = \sim.25$ - .45, which is similar to those reported for posttraumatic stress symptoms (Putnam, 1997). Peritraumatic dissociative reactions may be analogous to the freezing/numbing responses observed in animals exposed to prolonged and severe uncontrollable stress (Nijenhuis, van der Hart, Kruger, & Steele, 2004; van der Kolk, 1996). In the freezing/numbing response endogenous opioids are secreted after prolonged exposure to severe stress (Scaer, 2001; van der Kolk, Greenberg, Orr, & Pitman, 1989) helping the animal to survive. This suggests that peritraumatic dissociation may be an adaptive response to the experience of overwhelming trauma, possibly serving a protective function by limiting one's awareness to the devastating experience (Horowitz, 1997). Could the numbing response observed in the bereaved, by many in the field of grief research (McKissock & McKissock, 1995; Prigerson et al., 2000; Raphael & Martinek, 1997; Regehr & Sussman, 2004), be a reaction to the overwhelming distress experienced soon after bereavement?

Given the broadness in the definition of dissociation there is an argument for research being better served if specific aspects of dissociation, such as, emotional numbing, reduced awareness, amnesia, derealisation and depersonalisation, were the focus of interest rather than the general term itself. This would facilitate a better understanding of the information processing mechanisms that underlie dissociative reactions to traumatic experiences.

In summary, various constructs of pathological grief have been inadequately defined for many years. The more recent proposals, of Complicated Grief Disorder and TG, offer criteria that allow for the distinction between these syndromes and other forms of grief. Both of these proposals highlight the traumatic aspects of the symptomatology rather than the traumatic nature of the death. The extension of Criterion A1 for PTSD, in the fourth version of the DSM, has resulted in a marked increase in the number of people being diagnosed with PTSD, a vast number of these have arisen after bereavement. Considering that dissociation is apparent in many cases of PTSD and that the "learning about unexpected or violent death.... by a family member or other close associate" (American Psychiatric Association, 2000, p.463) is a Criterion A1 event, it follows that dissociation in the bereaved is an area that is in need of investigation, and to date, has not received much interest from either thanatologists or traumatologists. Given that most people have or will experience bereavement and of this group some may develop a pathological form of grief, this investigation will examine the presence of dissociation in a bereaved population. Because it has clear criteria and measures symptoms of traumatic distress in the bereaved the type of grief pathology selected for investigation is TG.

2.3.0 Aims of the thesis

It is proposed that dissociation may be an aspect of the grief experience for those who have been traumatised by bereavement. The current study therefore attempts to answer the question of whether there is a relationship between dissociation and TG. The purpose of this study is to investigate if

dissociation is more frequent in those bereaved that meet criteria for TG compared to those bereaved who do not. It also aims to establish if those bereaved with a history of traumatic life events dissociate more frequently and report greater general psychological distress than those with no history or with a history of lesser stressful life events. This investigation proposes four research hypotheses that are as follows: In a sample of bereaved individuals,

1. The frequency of dissociation, as measured by the Dissociative Experiences Scale, will be greater in those who meet symptom criteria for TG compared to those who do not meet criteria for TG;

2. General psychological distress, as expressed in poorer General Health Questionnaire-28 scores, will be greater in those who meet symptom criteria for TG compared with those who do not meet criteria for TG;

3. Those who have experienced more incidents of trauma, as measured by the Stressful Life Events Screening Questionnaire, will show greater frequency of dissociation on the Dissociative Experiences Scale, compared with those who have fewer incidents of trauma and;

4. Those who report more incidents of trauma will show greater general psychological distress, as expressed in poorer General Health Questionnaire-28 scores, compared with those who have fewer incidents of trauma.

3.0.0 Research participants

Individuals who had experienced bereavement were recruited from a newspaper article, self help groups, bereavement counselling services and first year psychology lectures. Of the 78 participants that returned questionnaires, 29 of the participants were eliminated either because the participant had experienced a bereavement in the previous six months (n = 8), the bereavement was more than 10 years ago (n = 9), insufficient information was provided (n = 9), the mourning was for multiple deaths from a single event (n = 2), or the participant did not fit any of the categories being analysed (n = 1). The time span of bereavement commencing at six months to 10 years was chosen because a period of bereavement of three to six months, as opposed to a period of zero to three months, was found to have good predictive validity 18 months after the loss for global functional impairments, such as, sleep disturbance, low self-esteem and anxiety (Prigerson, Frank et al., 1995). Bereavement less than 10 years was a common denominator across the three groups that were later formed and therefore a limit of 10 years best enabled comparisons between the groups. As the overall level of TG symptom severity, after the initial acute phase of grief, has been found to be stable over time (Bolen & van den Bout, 2002-2003; Prigerson et al., 1997), participants who had been bereaved many years previously were included in this investigation.

Of the 49 accepted respondents, seven were male and 42 female, ranging in age between 23-78 years (M = 51.43 years, SD = 11.86 years). Time elapsed since the death of the family member or close associate ranged from six months to ten years (M = 3.34 years, SD = 2.88 years).

Although most participants were drawn from one metropolitan newspaper article and only three participants came from university classes, more than a third of the participants had tertiary qualifications. The distribution of income demonstrated that the majority earned less than $40,000 per annum, and were bereaved through the loss of immediate relatives with the most frequent loss being that of their partner.

3.0.1 Research groups

There were sufficient numbers of volunteers who met and who did not meet symptom criteria for TG to enable comparisons between the two groups. In order to test the first two hypotheses the participants were divided into three groups on the basis of the condition of TG, as defined by the Inventory of Traumatic Grief (Prigerson & Jacobs, 2001), and PTSD, as defined by the Posttraumatic Stress Diagnostic Scale (Foa, 1995). The purpose of the groups was to delineate the effect of TG and PTSD on the measures of dissociation, general psychological distress and traumatic life events and ensure that the results obtained were not due to the presence of PTSD. The clinical groups were:

a. TG+ PTSD group (n = 16): those who met symptom criteria for both Traumatic Grief and Posttraumatic Stress Disorder.
b. PTSD group (n = 10): those who did not meet criteria for Traumatic Grief but who met criteria only for Posttraumatic Stress Disorder.
c. Control group (n = 23): those who did not meet symptom criteria for either Traumatic Grief or Posttraumatic Stress Disorder.

Criteria for TG and PTSD are shown in Table 2 and 3.

Table 2.

Inventory of Traumatic Grief - criteria for Traumatic Grief.

Criteria for Traumatic Grief
A The death of a significant other
A At least three of five separation distress symptoms, see below, reported as greater or equal to four points on a five point scale[†] 1) I think of the deceased so much that it can be hard for me to do the thing I normally do 2) Memories of the deceased upset me 3) I feel myself longing and yearning for the deceased 4) I feel drawn to places and things associated with the deceased 5) I feel lonely ever since the death
B At least six of twelve traumatic distress symptoms, see below, reported as greater or equal to four points on a five point scale[†] 1) I feel that I have trouble accepting the death 2) I can't help feeling angry about the death 3) I feel disbelief over the death 4) I feel stunned, dazed, or shocked over the death 5) Ever since the death I feel like I have lost the ability to care about other people or I feel distant from people I care about 6) I go out of my way to avoid reminders that the deceased is gone 7) I feel that life is empty or meaningless without the deceased 8) I feel like I have become numbed since the death 9) I am bitter over the death 10) I feel like the future holds no meaning or purpose without the deceased 11) I feel unable to imagine life being fulfilling without the deceased 12) I have lost my sense of security or safety since the death
C Duration of symptoms is greater than two months
D Impairment in social, occupational or other areas of function is reported as greater or equal to four points on a five point scale

[†] Note: Anchor points on the scale concern either frequency or intensity of feeling.

Frequency: Almost never (less than once a month), rarely (once a month or more, less than once a week), sometimes (once a week or more, less than once a day), often (once every day), and always (several times a day).

Intensity: No sense of the feeling, a slight sense, some sense, a marked sense, and an overwhelming sense.

Table 3.

Posttraumatic Stress Diagnostic Scale - criteria for PTSD.

	Criteria for PTSD
A	Exposed to a traumatic event in which both of the following were present:
A1	The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
A2	The person's response involved intense fear, helplessness or horror
B	The traumatic event is persistently re-experienced in one (or more) of the following ways: 1) recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions 2) recurrent distressing dreams of the event 3) acting or feeling as if the traumatic event were recurring (includes sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
C	Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following: 1) efforts to avoid thoughts, feelings, or conversations associated with the trauma 2) efforts to avoid activities, places, or people that arouse recollections of the trauma 3) inability to recall an important aspect of the trauma 4) markedly diminished interest or participation in significant activities 5) feelings of detachment or estrangement from others 6) restricted range of affect (e.g. unable to have loving feelings) 7) sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span
D	Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following: 1) difficulty falling or staying asleep 2) irritability or outbursts of anger 3) difficulty concentrating 4) hyper-vigilance 5) exaggerated startle response
E	Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month
F	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Given that the number of participants remaining for inclusion in a fourth group, that of those meeting criteria only for TG, was a single individual, the data from this individual was not included in the comparative group analyses or demographic information reported, leaving a total of 49 participants.

In order to test the third and fourth hypotheses, the three clinical groups were dissolved and participants' responses were reclassified into one of five categories of traumatic life events on the basis of their scores on the Stressful Life Event Screening Questionnaire. These are as follows:

1. no traumatic events (*n = 8)*
2. single non-interpersonal traumatic life event - life threatening illness, accident, traumatic loss, and witnessing a death or assault, (*n = 14)*
3. single interpersonal traumatic life event - molestation, physical assault, attempted and successful forced sexual penetration or rape, (*n* = 6)
4. ongoing interpersonal traumatic life event - repeated episodes of the one type of traumatic event by the same perpetrator (*n = 6)*
5. multiple interpersonal traumatic life events - two or more events by different perpetrators in the interpersonal category, (*n = 15)*

Bereavement alone was not considered a traumatic life event, however, the nature of that bereavement may have constituted a traumatic loss and accordingly was classified as a single non-interpersonal traumatic life event. Further information on the classification of categories is provided in the next section that describes in greater detail the Stressful Life Events Screening Questionnaire.

3.1.0 Materials

3.1.1 Inventory of Traumatic Grief (ITG)

The Inventory of Traumatic Grief (Prigerson & Jacobs, 2001) is a 34 item questionnaire of separation and traumatic distress experienced in the past month (see Appendix A). This scale can be either self or interviewer-administered and is a measure of maladaptive grief arising from bereavement. Symptoms are organised into one of the two clusters, one of Separation Distress and another of Traumatic Distress and these underpin the diagnosis of TG. Within the Inventory of Traumatic Grief, scores for both these clusters are provided as well as the level of impairment the respondent believes has resulted from the grief experienced. Questions in the separation cluster relate to intrusive yearning, longing, searching, and loneliness. Questions on the traumatic cluster are concerned with efforts to avoid reminders of the deceased, feeling numbed, shocked, or dazed by the loss, having difficulty acknowledging the death, feelings of futility and a fragmented sense of security and control. The Inventory of Traumatic Grief, full scale, has been shown to have high internal consistency (Cronbach's alpha = .95) with a sensitivity and a specificity level of 0.93 (Prigerson & Jacobs, 2001). The sensitivity and specificity of the Inventory of Traumatic Grief was determined by the correct identification of "caseness" of TG according to the Widowhood Questionnaire. The top 20% of the distribution of scores on the Inventory of Complicated Grief, which were those of participants who scored above 25, was used to determine caseness of TG as these participants were found to have significantly worse scores than those who scored 25 or less on the following quality of life measures on the Medical Outcomes Survey Short-Form General Health Survey

(Stewart & Ware, 1988): general health (t = 2.51, df = 28, p = .02), mental health (t = 4.92, df = 28, p = .0001, physical health (t = 3.70, df = 28, p = .0009), social functioning (t = 2.49, df = 9, p = .04) and bodily pain measures (t = 20.57, df = 28, p = .02). In addition to these, there was a trend towards more impaired role performance (t = 1.78, df = 28, p = .09) on the Medical Outcomes Survey Short-Form General Health Survey (Prigerson, Maciejewski et al., 1995). The full scale of the Inventory of Traumatic Grief is used in this investigation.

3.1.2 Stressful Life Events Screening Questionnaire (SLESQ)

The Stressful Life Events Screening Questionnaire (Goodman et al., 1998) measures traumatic incidents that have occurred at any time from early childhood onwards. It is designed to identify Criterion A1 events associated with PTSD described in the DSM-IV and is a 15 item questionnaire covering a range of traumatic life events including life threatening incidents, physical abuse, sexual abuse, assault, and the frequency, subjective impact and time span of these events. In this investigation three behaviourally specific questions relating to explicit sexual contact, such as sexual intercourse, anal sex, oral sex, and the touching of private parts, were combined into two questions referring to all the above as intimate sexual contact (see Appendix B). The rationale for this was to minimise under-reporting of traumatic sexual experiences, especially amongst those less willing to identify the nature of abuse. There is evidence to indicate that those who have difficulty discussing sexual abuse under report their experiences by about a third (Finkelhor, Hotaling, Lewis, & Smith, 1990) and for this reason it was decided in this investigation that the questions should be combined under the one term "intimate sexual contact" to

encourage reporting of sexual abuse. Responses were grouped in similar levels of trauma severity identified by Green et al. (2000). The Stressful Life Events Screening Questionnaire was scored in two ways; a tally of the number of stressful life events in order to obtain a total score for each individual, and rank ordering the events using a similar method employed by Green et al., where events were classified according to categories along a continuum of trauma severity. In order to identify events experienced by each participant, Green et al. used six different categories, including a "Non-Criterion A1 only" group. This investigation, however, classifies the events according to five categories as it does not include a non-Criterion A1 traumatic event group. The reason for omitting this is that the Stressful Life Events Screening Questionnaire is a questionnaire of Criterion A1 events only and this investigation did not seek to study non-Criterion A1 events. Additional to this, unlike Green et al., those who had experienced mixed events, i.e. both interpersonal and non-interpersonal, were included because more than half the participants in this investigation had experienced mixed events. In accordance with the classification of Green et al., single interpersonal and single non-interpersonal events were classified under separate categories, with a single non-interpersonal event considered to be of lesser traumatic severity than a single interpersonal event. The categories range in severity from "no trauma" "single non-interpersonal trauma", "single interpersonal trauma", "ongoing interpersonal trauma" and "multiple interpersonal traumatic events". Where individuals had experienced events that may be categorised under multiple classifications, they were categorised according to the most severe event.

The Stressful Life Events Screening Questionnaire measures traumatic events that have occurred over the lifetime of the respondent. It has good test-retest reliability (0.89) with a median kappa of 0.73 and good convergent reliability (0.77) (Goodman et al., 1998). These estimates of test-retest reliability, convergent validity and concurrent validity were obtained from two methods of administration. Concurrent validity was determined using two screenings of respondents. The first was a self-administered completion of the Stressful Life Events Screening Questionnaire by the respondents, and the second was an interview with a series of questions adapted from a variety of sources, a semi-structured sexual abuse interview (Russell, 1986), the Potential Stressful Events Inventory (Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993), the trauma history interview used in the DSM-IV (American Psychiatric Association, 2000) field trials and the Conflict Tactics Scale (Strauss, 1989). Convergent validity was established via a subset of respondents providing the same responses to a more detailed interview two weeks after the first screening (Goodman et al., 1998).

3.1.3 Dissociative Experiences Scale (DES)

The Dissociative Experiences Scale (E. B Carlson & Putnam, 1993) is a 28 item questionnaire used to assess the frequency of dissociative experiences in current daily living which is taken as a trait measure of dissociation and scores are expected to be stable over shorter periods of time (refer to Appendix C). It is the most widely used self-administered dissociative experiences scale (Wright & Loftus, 2000). The Dissociative Experiences Scale has been demonstrated to have good test-retest reliability ($r = .79$), (Pitblado & Sanders, 1991), high internal reliability, (Cronbach's alpha = .95),

(Frischholz et al., 1990) and favourable construct validity, r = .52 (Frischholz et al., 1991) and r = .82 (Nadon, Hoyt, Register, & Kihlstrom, 1991). The latter was determined by both Frischholz et al. (1991) and Nadon et al. (1991) by comparing the Dissociative Experiences Scale to a measure that is said to measure both normal and abnormal dissociation, the Perceptual Alteration Scale, (Sanders, 1986). The Dissociative Experiences Scale has been used with both clinical and non-clinical populations (Ray & Faith, 1995; Ross et al., 1990). The response scale for all 28 items is a visual analogue scale, in units of 10, indicating the percentage of time, from 0% to 100%, that the respondent has experienced the specified dissociative event, such as "Some people have the experience of looking in a mirror and not recognising themselves" and "Some people have the experience of feeling that other people, objects, and the world around them are not real". The total score is derived from the average score for all items. A score of 30, out of a maximum possible score of 100, is considered indicative of a dissociative type disorder (E. B Carlson & Putnam, 1993).

3.1.4 General Health Questionnaire-28 (GHQ-28)

The 28 item version of the General Health Questionnaire (Goldberg & Hillier, 1979) is a reliable and extensively validated screening instrument of psychiatric symptoms in community and non-psychiatric clinical settings (Goldberg, 1985). It measures symptoms experienced over the past few weeks, across four factors: anxiety and insomnia, somatic symptoms, severe depression and social dysfunction (refer to Appendix D). Goldberg and Williams (1991) describe four approaches to scoring and the implications of these different methods. In this investigation, a 4-point Likert-type scale with

options of 'Not at all' (1), 'Same as usual' (2), 'Rather more than usual' (3) and 'Much more than usual' (4), was used to capture intensity of symptoms as well as type of symptoms experienced. "Same as usual" is given a higher score than "Not at all" to ensure that chronic symptoms are detected following Goldberg and Williams' suggestion. The higher the score the greater the level of symptomatology experienced by the participant. Internal consistency reported for the General Health Questionnaire-28 is 0.95. Correlation coefficients between the General Health Questionnaire-28 and the Clinical Interview Schedule (Goldberg, Cooper, Eastwood, Kedward, & Shepard, 1970) demonstrated a correlation range across the subscales from 0.32 to 0.76. The subscale with the lowest correlation coefficient is the somatic symptoms scale. The General Health Questionnaire-28 has a sensitivity of 0.86 and a specificity of 0.82, which are the median values determined from 12 different validity studies of the General Health Questionnaire-28 on differing populations of both clinical and non-clinical groups, ranging from 22 to 352 participants, from school girls and unemployed adolescents to patients in primary care and medical specialist settings (Goldberg & Williams, 1991). Most of these studies used the Clinical Interview Schedule (Goldberg et al., 1970) to identify those participants showing a clinically significant disorder (the true cases) from those who show both the ability to conduct their normal, healthy functions and not be experiencing new phenomena of a distressing nature (the true non-cases) (Goldberg & Williams, 1991). In clinical populations where there is a high prevalence of disorder, test-retest correlations have been found to be 0.90 (Robinson & Price, 1982).

3.1.5 Posttraumatic Stress Diagnostic Scale (PDS)

The Posttraumatic Stress Diagnostic Scale (Foa, 1995) is a 49 item self-report instrument designed to facilitate the diagnosis of PTSD (see Appendix E). The Scale was examined against the Structured Clinical Interview for DSM-III-R and was found to have a sensitivity of 0.82 and specificity of 0.77 for the diagnosis of PTSD. It follows DSM-IV diagnostic criteria for PTSD and covers symptoms experienced in the past month. It was developed as a brief self-report instrument to aid reliable diagnosis of PTSD and demonstrates good test-retest reliability (kappa of 0.74 with a percentage agreement between the two administrations of 87.3%) for both PTSD diagnosis and symptom severity. Strong internal consistency has been shown for the Posttraumatic Stress Diagnostic Scale, with Cronbach's alphas of .92 for the total PTSD symptom severity score and .78 for re-experiencing, .84 for avoidance and .84 for arousal subscales (Foa et al., 1997). The Posttraumatic Stress Diagnostic Scale was validated on a normative sample of 248 subjects using the Beck Depression Inventory (Beck & Steer, 1987), the State-Trait Anxiety Inventory (Spielberger, 1983), the Impact of Event Scale (Horowitz, 1992) and the PTSD module of the Structured Clinical Interview for the DSM-III-R (American Psychiatric Association, 1987). Moderate correlations between the Symptom Severity score on the Posttraumatic Stress Diagnostic Scale and these measures were reported to range from .66 to .80. They were Beck Depression Inventory (.79), State-Trait Anxiety Inventory-S (.73), State-Trait Anxiety Inventory-T (.74), Impact of Event Scale-I (.80) and Impact of Event Scale-A (.66). The Posttraumatic Stress Diagnostic Scale's degree of sensitivity and specificity

was sufficiently high to be considered to have good overall diagnostic agreement with the Structured Clinical Interview for DSM-III-R (Foa, 1995).

3.1.6 Information Sheets

A personal information sheet sought demographic and bereavement information from participants (see Appendix F). It consisted of 10 questions relating to their demographic details, information about the relationship with the deceased, time elapsed since the death of the family member or close associate, number of counselling sessions since their bereavement and participants' perception of their current coping levels. It was accompanied with a general information sheet that briefly explained this investigation and what was required of participant (refer to Appendix G for details).

3.2.0 Procedure

Questionnaires were randomly ordered, with a personal information sheet appearing immediately after the general information sheet, and mailed with a stamped return addressed envelope to all respondents who agreed to participate. All interested participants were informed that participation was voluntary and withdrawal was permissible at any time. Consent was implied through completion and return of the questionnaires. The names of counselling centres were also provided on the general information sheet. The Tasmanian Social Sciences Human Research Ethics Committee granted ethical approval for the investigation.

3.3.0 Data Analysis

Analyses of variance with Tukey HSD post-hoc tests were used to examine group differences on continuous and normally distributed dependent variables. Kruskal-Wallis tests and Games-Howell post-hoc tests were applied to examine group differences on dependent variables. Chi-square analyses were used to examine differences in observed frequencies between groups. Finally, Spearman correlations were applied to examine relationships between continuous and rank-ordered variables. A two-tailed alpha significance level of .05 was applied for all analyses.

4.0.0 Demographic characteristics

Of the original 78 sets of returned questionnaires, 49 were eligible for inclusion in the analysis. Demographic details concerning sex, education, income, type of loss, current partnership status in the three clinical groups are presented in Table 4.

Table 4.

Demographic characteristics of participants in the clinical groups.

	Clinical Groups						
	Control N=23		PTSD N=10		TG+PTSD N=16		Total N=49
	n	Percentage	*n*	Percentage	*n*	Percentage	*N*
Sex							
Male	*5*	21.7	*1*	10.0	*1*	6.2	*7*
Female	*18*	78.3	*9*	90.0	*15*	93.8	*42*
Education Levels							
Primary school	*0*	0.0	*0*	0.0	*1*	6.3	*1*
Year 10	*9*	39.1	*3*	30.0	*4*	25.0	*16*
Year 12	*1*	4.3	*1*	10.0	*1*	6.3	*3*
TAFE	*7*	30.4	*3*	30.0	*3*	18.8	*13*
University	*6*	26.1	*3*	30.0	*7*	43.8	*16*
Income Distribution							
Less than $20,000	*7*	30.4	*4*	40.0	*4*	25.0	*15*
$20,000- $40,000	*8*	34.0	*2*	20.0	*7*	43.8	*17*
$41,000- $60,000	*6*	26.1	*3*	30.0	*3*	18.8	*12*
$61,000 and above	*2*	8.6	*1*	10.0	*2*	12.5	*5*
Type of Loss							
Partner	*14*	60.9	*3*	30.0	*4*	25.0	*21*
Parent	*6*	26.1	*1*	10.0	*4*	25.0	*11*
Offspring	*1*	4.3	*4*	40.0	*8*	50.0	*13*
Other relative or friend	*2*	8.7	*2*	20.0	*0*	0.0	*4*
Partnership status							
Never married	*2*	8.7	*1*	10.0	*2*	12.5	*5*
Separated/Divorced	*1*	4.3	*1*	10.0	*3*	18.8	*5*
Widowed	*14*	60.9	*4*	40.0	*3*	18.8	*21*
Married	*6*	26.1	*4*	40.0	*8*	50.0	*18*
De facto spousal relationship	*0*	0.0	*0*	0.0	*0*	0.0	*0*

The distribution, within the three clinical groups, of means, standard deviations, age range of participants and the time since the death of the family member or close associate are presented in Table 5.

Table 5.

Means and standard deviations within the clinical groups for age range and years since the death of the family member or close associate.

	CLINICAL GROUPS					
	Control Group (n = 23)		PTSD Group (n = 10)		TG+PTSD Group (n = 16)	
	Mean (SD)	Range	Mean (SD)	Range	Mean (SD)	Range
Age	54.2 (10.3)	33.0 - 78.0	49.2 (14.7)	23.0 - 62.0	48.8 (11.9)	25.0 - 75.0
Years	3.7 (2.9)	0.5 - 9.5	3.9 (3.6)	0.6 - 10.0	25.0 (2.2)	0.6 - 8.0

Although the age range of participants is 23 to 78 years, 79.6% were 45 years of age or older. The median age was 54 years. Univariate analyses of variance revealed no significant difference between the three groups with respect to both age, $F(2,48) = 1.66$, $MSE = 140.08$, $p = .20$, power = .33 and the time lapsed since the death of the family member or close associate, $F(2,48) = 1.12$, $MSE = 8.28$, $p = .34$, power = .23. In spite of there being a high representation of tertiary training amongst the participants (32.7% of the sample), a chi-square analysis showed no significant difference between the three groups with respect to being tertiary trained, $\chi^2 (2_{n=49}) = .50, p = .63$.

4.1.0 Clinical groups

4.1.1 Clinical groups and frequency of dissociation

It was hypothesised that those who meet criteria for TG will report greater frequency of dissociation, as indicated by Dissociative Experiences Scale scores. For this reason, the frequency of dissociation and its association with TG was investigated. Scores on the Dissociative Experiences Scale above 20 are considered worthy of further clinical investigation (E. B Carlson & Putnam, 1993). Such scores were observed in two of the twenty-three participants in the Control group (8.6%), three of the ten participants in the PTSD group (30%) and in seven of the sixteen participants in the TG+PTSD group (44.1%). A univariate analysis of variance on the clinical groups and the Dissociative Experiences Scale scores revealed that there was a significant difference between the three groups on the Dissociative Experiences Scale scores, $F(2,46) = 5.57$, $MSE = 166.89$, $p = .007$, power = .83 (Table 6).

Post hoc analysis, using the Tukey HSD test at an alpha of .05, revealed that the TG+PTSD group had significantly higher scores on the Dissociative Experiences Scale than the Control group. However, there was no significant difference between TG+PTSD and PTSD group scores on the Dissociative Experiences Scale. There was also no significant difference between the PTSD and Control group on this measure. This suggests that, among this sample, those with a combined presentation of TG and PTSD experience a significantly greater frequency of dissociation than those who have neither condition. However, those with the combined presentation did not report a greater frequency of dissociation than those with PTSD only.

4.1.2 Clinical groups and general psychological distress

It was hypothesised that those who meet criteria for TG would report greater general psychological distress. For this reason the severity of responses on the General Health Questionnaire-28 and its association with TG was investigated. A univariate analysis of variance revealed that there was a significant difference among the three groups on their General Health Questionnaire-28 scores, $F(2, 46) = 8.73$, $MSE = 205.59$, $p < .001$ power = .96 (Table 6).

Post hoc analysis using the Tukey HSD test at an alpha of .05 revealed that the TG+PTSD and PTSD groups had significantly higher scores on the General Health Questionnaire-28, indicating greater general psychological distress, than the Control group. However, there was no significant difference on General Health Questionnaire-28 scores between the PTSD and TG+PTSD groups. This suggests that whether there was a single condition present, of PTSD, or two conditions present, of both PTSD and TG, the effect of this on general psychological distress scores is similar.

4.1.3 Clinical groups and traumatic life events

As dissociation has been associated with traumatic experiences (Cardena & Spiegel, 1993; Chu & Dill, 1990; Murray et al., 2002), the severity of other traumatic life events was explored through the use of the Stressful Life Events Screening Questionnaire. In order to identify the most severe event experienced by each participant the responses from the Stressful Life Events Screening Questionnaire were ranked ordered from one to five, similar to the rank ordering of categories by Goodman et al. (1998) as described in the

previous chapter (Section 3.2.2). In order to determine means and standard deviations for the Stressful Life Events Screening Questionnaire rank ordering was not suitable, instead the total number of traumatic life events reported on the Stressful Life Events Screening Questionnaire by participants was used. A Kruskal Wallis test was performed on the clinical groups to determine the severity of the categories of traumatic life events on the groups. It revealed that the differences in severity of traumatic life events amongst the participants in each of the groups, as measured on the Stressful Life Events Screening Questionnaire, was trending toward significance: χ^2 $(2_{n=49}) = 5.883$, $p = .053$, suggesting that the severity of traumatic life events may have varied between groups (Table 6).

A post hoc analysis, using the Games-Howell test, was conducted to determine if there were any trends between the groups. The test showed the PTSD group trending towards a greater severity of traumatic life events than the Control group ($p = .07$). Means and standard deviations for all three clinical groups and the dependent variables, scores on the Dissociative Experiences Scale, General Health Questionnaire-28 and Stressful Life Events Screening Questionnaire, are displayed in Table 6.

Table 6.

Means, standard deviations on the DES, GHQ-28 and SLESQ and number of traumatic life events within the clinical groups.

	CLINICAL GROUPS							
	Control *n = 23*		PTSD *n = 10*		TG+PTSD *n = 16*		Statistical Significance	Post-Hoc
	Mean	(SD)	Mean	(SD)	Mean	(SD)		
DES	8.0	(8.9)	12.5	(8.3)	22.0	(18.8)	$F = 5.6^{**a}$	T > C
GHQ-28	23.2	(13.5)	36.2	(15.4)	42.1	(14.9)	$F = 8.7^{***a}$	T, P > C
SLESQ†	2.2	(1.8)	3.1	(2.8)	2.8	(2.6)	$x^2 = 5.9(*)^{ab}$	P > C
Traumatic Life event categorie								
No traumatic Events		7		0		1		
Single, non-interpersonal		6		3		5		
Single, Interpersonal		2		2		2		
Ongoing Interpersonal		5		0		1		
Multiple Interpersonal		3		5		7		

Note: DES =Dissociative Experiences Scale, GHQ-28 = General Health Questionnaire 28, SLESQ= Stressful Life Events Screening Questionnaire.

(*)p < .1; **p < .01; ***p < .001; C = Control; P = PTSD; T = TG+PTSD.

†Means and standard deviations derived from participants' sum of stressful life events.

[a] degree of freedom = 2

[b] Kruskal Wallis test was performed on the clinical groups to determine the severity of the categories of traumatic life events on the groups

4.2.0 Traumatic life events

4.2.1 Traumatic life events and dissociation

According to their responses on the Stressful Life Events Screening Questionnaire most participants had experienced a number of traumatic life events with 83.7% of the sample having reported at least one traumatic event that is a DSM-IV, Criterion A1 event for PTSD. Almost one third, 30.6%, of

the participants reported having experienced multiple Criterion A1 events and just under two thirds, 58%, reported traumatic events of both an interpersonal and non-interpersonal nature.

It was hypothesized that those who have experienced more severe incidents of trauma will show greater frequency of dissociation and for this reason the frequency of dissociation and its relationship to the severity of traumatic life events was investigated. A Spearman's correlation revealed that there was a significant relationship between the traumatic life event category and the frequency of dissociation $rho = .29$, $p < .05$. Means and standard deviations for the participants ($N= 49$) are displayed in Table 7. This result indicates that the frequency of dissociation reported by the participants is correlated with the severity of traumatic life events they had experienced. However, if the multiple interpersonal traumatic life event category is excluded from the analysis, the analysis fails to show a significant correlation between the traumatic life event category and frequency of dissociation, $rho = -.08$, $p = .66$. A univariate analysis of variance conducted on the full sample revealed a similar finding with a significant main effect for the categories of traumatic life event on the frequency of dissociative experiences, $F(4, 44) = 2.75$, $MSE = 173.38$, $p = .04$, power = .71. However, when the multiple interpersonal traumatic life event category was excluded again from the analysis, the analysis failed to show a significant difference $F(3, 30) = .34$, $MSE = 81.75$, $p = .80$, power = .11. In order to determine the differences between the categories a post hoc analysis was conducted using the Games-Howell test at an alpha of .05. A trend towards a significant difference was found between the multiple and on-going interpersonal traumatic life event categories. This suggests that

those who had experienced multiple interpersonal traumatic life events had significantly greater levels of dissociation according to the Dissociative Experiences Scale in comparison to those experiencing ongoing interpersonal traumatic life events, but there were no differences in the extent of dissociation between those in all other categories of traumatic life events

4.2.2 Traumatic life events and general psychological distress

It was hypothesized that those who report a greater severity of traumatic life events will show greater levels of general psychological distress and for this reason the severity of categories traumatic life events and general psychological distress, as operationalised by the General Health Questionnaire-28, was investigated. A Spearman's correlation revealed that there was no relationship between the traumatic life event category and current general psychological distress, *rho* = *.11, p* = .45, means and standard deviations for the participants (*N* = *49*) are displayed in Table 7. As such this suggests that there was no significant relationship between increased severity of traumatic life events and general psychological distress.

4.2.3 Traumatic life events and Posttraumatic Stress Disorder symptoms

Although it did not form part of the hypotheses, the Posttraumatic Stress Diagnostic Scale-symptom severity score was included in the analysis. The reason for this was to determine if the severity of the traumatic symptoms followed a similar pattern to dissociation and general psychological distress. Similar to the scores on the Dissociative Experiences Scale, the symptom severity scores correlated with the traumatic life event category. A Spearman's correlation revealed that there was a significant association between the

traumatic life event category and the severity of trauma symptoms as measured by the Posttraumatic Stress Diagnostic Scale –symptom severity score, *rho* = .40, $p = .005$. This result indicates that the severity of posttraumatic stress symptoms reported by the participants is correlated with the severity of traumatic life events they had experienced. However, if the multiple interpersonal traumatic event category is excluded from the analysis, the analysis fails to show a significant correlation between the traumatic life event category and severity of posttraumatic stress symptoms reported, *rho* = .24 $p =$ .18. A univariate analysis of variance conducted on the full sample revealed a similar finding with a significant main effect for the traumatic life event category on the severity of posttraumatic stress symptoms, $F(4,44) = 2.96$, $MSE = 552.59$, $p = .03$, power = .75. In order to determine the differences between the categories, a post hoc analysis using the Games-Howell test at an alpha of .05 was conducted. A significant difference was found between the multiple interpersonal traumatic life event category and the no event category, ($p = .02$), suggesting that the severity of PTSD symptoms is increased by the experience of multiple interpersonal traumatic life events, but there was no significant difference in the severity of PTSD symptoms between those experiencing single and ongoing traumatic life events, and no difference in severity of PTSD symptoms between all other categories of traumatic life events.

Means and standard deviations for scores on the Dissociative Experiences Scale, General Health Questionnaire-28 and Posttraumatic Stress Diagnostic Scale, are displayed in Table 7, according to their ranked ordered

traumatic life event category, determined from responses to the Stressful Life Events Screening Questionnaire.

Table 7:

Means and standard deviations on the DES, GHQ-28 and PDS-symptom severity, for the categories of traumatic life events.

Traumatic Life Event Categories	*N*	DES	GHQ-28	PDS-symptom severity scale
	49			
		Mean (SD)	Mean (SD)	Mean (SD)
No traumatic events	*8*	10.7 (11.4)	29.0 (9.8)	6.8 (12.4)
Single non-interpersonal traumatic life event	*14*	9.9 (8.9)	31.6 (18.8)	19.1 (14.9)
Single interpersonal traumatic life event	*6*	9.8 (8.3)	33.0 (19.1)	21.0 (15.8)
On-going interpersonal traumatic life event	*6*	6.1 (5.9)	22.7 (14.7)	11.5 (13.5)
Multiple interpersonal traumatic life events	*15*	22.7 (19.2)	37.5 (16.6)	25.7 (12.2)
Spearman's rho, p		*.29, p =.04*	*.11, p =.45*	*.40, p = .005*
Spearman's rho†, p		*-.08, p =.66*	*-.13, p =.46*	*.24, p = .18*

Note: DES = Dissociative Experiences Scale, GHQ-28 = General Health Questionnaire 28, PDS = Posttraumatic Stress Diagnostic Scale.

†excludes multiple interpersonal traumatic life events group.

4.3.0 Demographic distributions

4.3.1 Distribution of the nature of death

Although all the participants had been bereaved, the distribution of those who had lost offspring and those who had lost family, or friends by homicide, suicide or accident did not appear to be evenly spread. As these particular events appeared comparatively over-represented in the groups that

reported the higher frequencies of dissociative experiences, that is, the TG+PTSD and PTSD groups, a chi-square analysis was conducted to determine if the distribution of these events was significantly different across the three groups and an analysis of variance was conducted to determine if these specific events are associated with the frequency of dissociative experiences. Chi-square analysis showed that those in the TG+PTSD group and PTSD group were significantly more likely to have lost an offspring (50.0% and 40.0%, respectively) than those in the Control group, (4.3%), χ^2 ($2_{n=49}$) = 11.23, p = .004. However, a univariate analysis of variance conducted on the full sample of 49 participants, independent of the three groups, revealed that there was no significant difference in the frequency of dissociative experiences between those who had lost offspring (M = 16.97, SD = 19.86) and those that had experienced other types of losses (M = 12.19, SD = 11.44): F (1,47) = 1.10, MSE = 198.27, p = .30, power = 0.17. This suggests that the frequency of dissociation was not related to the loss of an offspring.

Chi-square analysis revealed that those in the TG+PTSD and PTSD groups were significantly more likely to have experienced the loss of a family member, romantic partner or a very close friend by homicide, suicide or accident (75.0% and 70.0% respectively) than those in the Control group (21.7%), χ^2 ($2_{n=49}$) = 12.93 p = .002. However, a univariate analysis of variance conducted on the full sample, independent of the three groups, revealed that those who had reported the loss of a family member, romantic partner or a very close friend by homicide, suicide or accident (M = 15.94, SD = 16.26, n= 24) were not significantly more dissociative than those who did not report these experiences (M = 10.26, SD = 10.60, n= 25): F (1, 49) = 2.16,

MSE =189.95, $p = .15$, power = .30. This suggests that the frequency of dissociation was not related to the death of a family member, romantic partner or a very close friend by homicide, suicide or accident.

4.3.2 Representative sampling: Homicides, suicides and death of children

The distribution of traumatic life events such as death via homicide, suicide and the number of deaths of children was not evenly distributed across the three clinical groups, the Control group, the PTSD group, and the TG+PTSD group. These events were over-represented in participants in the TG+PTSD group and in those in the PTSD group. The skew in distribution raised questions concerning how this bias might affect the results of this study. Overall, it was found that these traumatic life events of homicide, suicide and the death of children were not associated with a greater frequency of dissociative responses for any clinical group. This finding showed that among the participants, the frequency of dissociation was independent of their relationship with the deceased and independent of the homicidal or suicidal nature of death experienced by the deceased.

4.3.3 Representative sampling: Demographic distributions

Most participants were recruited from a newspaper advertisement and selection, for the majority, was therefore self-initiated. There was a large representation of women and widows in this study, of whom 85.7% (95% CI: 75.9-95.5%) were female and 42.9% were widowed (95% CI: 29.0%-56.7%). This is significantly higher than that reported by the Australian Bureau of Statistics (2007c) for the general population of Tasmania, which is 51.0% and 6.9% respectively.

The income of participants, 65.3% (95% CI: 52-78.6%) of whom earned $40,000 or less, appeared to be particularly low. However, according to the Australian Bureau of Statistics (2007a) 61.3% (95% CI: 61.0-61.7%) of Tasmanians, between the ages of 45-54 years of age, earn less than $41,548 per annum, a similar level of income reported by participants in this investigation and therefore not significantly different to that found in the general population of Tasmania.

Additionally, there seemed to be a disproportionately high number of tertiary educated participants in this investigation. Statistical analysis found no significant difference in the representation of tertiary educated participants between the three clinical groups. Thus, it was concluded that tertiary training was the same across the clinical groups and could not be considered responsible for any differences arising between the clinical groups. Although 32.7% (95% CI: 19.5%-45.8%) of participants were tertiary trained which seemed disproportionally high, closer evaluation showed that this is not significantly different from that in the general population of Tasmania, which is 24.8% (95% CI: 24.6%-25.0%) (Australian Bureau of Statistics, 2007b).

Overall, after evaluating the representation of gender, income and education among the participants it was concluded that the income and education of these participants were representative of the general population of Tasmania. Women were over represented, which means that the findings of this investigation are more likely to apply to women than to men.

4.4.0 Summary

In conclusion, the findings show that, with the exception of one individual, those meeting the criteria for TG also met the criteria for PTSD. Also, compared to those who had neither of these clinical conditions, those meeting the criteria for both TG and PTSD, had significantly more dissociative experiences and greater general psychological distress. In addition, those who met criteria for both these clinical conditions or only for PTSD, showed no significant difference in their frequency of dissociation or general psychological distress. The severity of traumatic life events varied among the groups but did not reach statistical significance. A post hoc comparison between the three groups showed there was a trend towards the PTSD group reporting a greater severity of traumatic life events. Although there was a significant correlation found between the category of traumatic life event and the frequency of dissociative experiences, this correlation was due to the presence of a single category, that of the multiple interpersonal traumatic life events. Without the inclusion of this category there was no correlation between the different categories of traumatic life event and the frequency of dissociation. Furthermore, there was no association found between general psychological distress and severity of traumatic life events, indicating that general psychological distress was not related to the severity of traumatic life events experienced. A notable difference in traumatic life experiences among the groups was that of the nature of deaths experienced in the different groups. Those in the TG+PTSD and PTSD groups were significantly more likely to have lost an offspring and were also significantly more likely than the Control group, to have lost a family member, romantic partner, or close friend by

means of homicide, suicide or accident. The findings revealed that neither losing an offspring nor losing a significant person by means of homicide, suicide or accident had any bearing on their frequency of dissociation.

5.0.0 Discussion

5.0.1 Purpose and aims of this investigation

The purpose of the current study was to investigate if dissociation occurs more frequently in bereaved individuals who meet the criteria for Traumatic Grief (TG) compared with bereaved individuals not meeting these same criteria. The rationale for investigating the presence of dissociation in TG was to test the general proposition that bereavement can be sufficiently traumatic such that dissociation will occur. This study also sought to establish whether bereaved individuals with TG report general psychological distress to a greater degree than do bereaved individuals without TG.

The above two research questions arose from the knowledge that emotional numbing is a commonly reported reaction to bereavement and secondly, that dissociation is reported to occur after experiencing a traumatic event. If bereavement were to evoke psychological distress comparable to the distress observed in reactions to traumatic events, then it is conceivable that bereaved individuals with signs of a traumatic expression of grief, as in TG, might also show signs of dissociation. The assumption underlying this argument is that bereavement arising from the death of a significant other can be a traumatic experience in as much as non-bereavement life events can be traumatic. Consistent with this is the DSM-IV listing of the learning of the unexpected or violent death of a family member or other close associate as a Criterion A1 traumatic event for PTSD (American Psychiatric Association, 2000). This lends support to the proposition that, at times, bereavement can be sufficiently traumatic for dissociation to occur.

In this investigation, the primary aim was to determine whether or not a relationship exists between TG, dissociation and general psychological distress in bereaved individuals. The secondary aim of this investigation was to determine whether a personal history of severe traumatic life events affects the frequency of dissociation and level of general psychological distress. The importance of the rationale for being able to identify pathological grief is that its early detection can facilitate a timely delivery of an appropriate treatment. However, the investigation is made more difficult because there is currently no basis for distinguishing between pathological and normal grief, making it difficult to differentiate normal grief from pathological grief and other psychopathologies that may arise at the time of bereavement.

Four hypotheses, derived from the above discussion, tested the predictions that participants meeting symptom criteria for TG, in comparison with those who do not, will show:

- A greater frequency of dissociation, as expressed in higher scores on the Dissociative Experiences Scale (Hypothesis 1).
- A greater level of general psychological distress, as expressed in higher scores on the General Health Questionnaire-28 (Hypothesis 2).

Participants who experienced a higher degree of traumatic life events, as measured by the Stressful Life Events Screening Questionnaire, compared to those who have not, will show:

- A greater frequency of dissociation, as expressed in higher scores on the on the Dissociative Experiences Scale (Hypothesis 3).

- A greater level of general psychological distress, as expressed in higher scores on the General Health Questionnaire-28 (Hypothesis 4).

5.0.2 Summary of the key findings

The findings of this investigation are first, that the frequency of dissociation and the level of general psychological distress are significantly greater in bereaved individuals presenting with a combined presentation of TG and PTSD, compared with bereaved individuals not meeting the criteria for either TG or PTSD. Second, that bereaved individuals reporting multiple incidents of interpersonal trauma have a greater frequency of dissociative experiences and severity of PTSD symptoms compared to those who encountered no trauma. Third, that there was no significant difference between the bereaved individuals with respect to the type of traumatic life events experienced (no trauma, single non-interpersonal, single interpersonal, on-going, multiple) and their level of general psychological distress.

In considering the four hypotheses of this investigation, the findings supported the first hypothesis, namely that dissociative experiences occur more frequently in participants who met criteria for TG. The absence of a group consisting of participants with only TG, however, meant that this hypothesis could be evaluated only in the condition of a combined presentation of TG and PTSD. Accordingly, this finding may be interpreted as providing qualified support for Hypothesis One.

The results of this investigation also supported the second hypothesis, namely that general psychological distress, as expressed in higher scores on the General Health Questionnaire-28, is significantly greater in participants who

met the symptom criteria for the combined presentation of TG and PTSD. Again, the absence of a group consisting of participants with only TG meant this hypothesis could be evaluated only in the condition of a combined presentation of TG and PTSD. Accordingly, this finding may be interpreted as providing qualified support for Hypothesis Two.

In regard to the third hypothesis, the results showed there was a significantly greater frequency of dissociative experiences reported by participants in the multiple interpersonal traumatic life event category compared to the no trauma category. There was no significant difference in the frequency of dissociation between any of the other traumatic life event categories (single non-interpersonal, single interpersonal and on-going) and the no trauma category. It appears that multiple, interpersonal, traumatic life events are a requisite for a greater frequency of dissociative experiences to occur. As this difference was observed for only one of the four traumatic life event categories, the results only partially supported Hypothesis Three.

The fourth hypothesis was not supported because the findings revealed that there were no significant differences in the level of general psychological distress between the no trauma group and any of the traumatic life event groups, (i.e. single non-interpersonal, single, on-going and multiple interpersonal traumatic life events groups). The results therefore failed to confirm Hypothesis Four.

5.1.0 Methodological considerations

Several methodological factors relevant to the findings of this investigation need to be considered. These relate to the statistics for a small sample, the absence of a purely TG only group, and the variable impact of trauma on different individuals.

5.1.1 Sampling limitation: Statistics and a small sample size

This investigation was constrained by its small sample size. A multivariate analysis of variance was not performed because two of the three clinical groups had less than 20 participants and a multivariate analysis of variance is considered robust when the size of the group is not less than 20 (Garson, 2009). Similarly, chi-squares were not performed in some instances because the requisite condition that each cell has an expected frequency of five participants could not be fulfilled.

5.1.2 Sampling limitation: Absence of a Traumatic Grief only group and its implications

Except for one participant showing TG as an isolated condition, this investigation was generally unable to find empirical support for the occurrence of TG occurring independently of PTSD. As stated previously, this meant that it was not possible to assess the independent contribution of TG on the key measures of frequency of dissociation, level of general psychological distress and its interaction with participants' experiences of traumatic life events. Accordingly, all conclusions from this investigation about TG and its relationship with both dissociation and general psychological distress had to be evaluated in the context of Traumatic Grief co-presenting with PTSD.

5.2.0 Trauma, Traumatic Grief and traumatic life events

5.2.1 Impact of trauma

In this investigation, the number of traumatic life events reported on the Stressful Life Events Screening Questionnaire was averaged for each clinical group. The Stressful Life Events Screening Questionnaire does not incorporate a subjective measure of the experience of a traumatic event; therefore, the subjective impact on the participants could not be determined. Not all participants who experience a traumatic event are traumatised by it. For example, figures cited in the literature of the percentage of those exposed to a traumatic event who develop PTSD range from 5% (Ozer, Best, Lipsey, & Weiss, 2003) to 14% (Breslau et al., 1998). The Stressful Life Events Screening Questionnaire score reports solely on the incidence or prevalence of traumatic events. It is necessary to be wary of assuming traumatisation from such a statistic because of the individual differences in the subjective experience of a traumatic event.

5.2.2 Prevalence and definition of trauma

The number of participants in this investigation who reported a lifetime prevalence of one or more traumatic events is 83.7%. This percentage is similar to that observed by Breslau (1998) but is significantly greater than that reported by Kessler et al. (1995) and Green et al. (2000).

Breslau et al. (1998) reported a rate of lifetime prevalence for trauma of 89.7% (95% CI: 88.5-91.0%) in a population of 2181 persons. This is not significantly different from the 83.7% (95% CI:73.3-94.0%) observed in this investigation. In Breslau et al.'s study, as in this investigation, traumatic event

was defined according to Criterion A1 for PTSD in the DSM-IV (American Psychiatric Association, 2000). These statistics show that the incidence of traumatic life events experienced by the participants in this investigation is representative of that found in a normal population.

Kessler et al. (1995) reported a prevalence of 55.8% (95% CI:54.5-57.0%) in their population of 5877 persons from a subsample of a National Comorbidity Survey. Their lower prevalence may be due to their narrow definition of trauma. Unlike the current investigation, Kessler et al.'s definition of trauma does not include the DSM-IV criterion, "learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (American Psychiatric Association, 2000, p. 463).

In a study of 1909 females by Green et al. (2000), the prevalence was 54.5% (95% CI: 52.3-56.8%). Although this investigation used a similar method of classifying participants as employed by Green et al. (2000), in this investigation the criteria for coding the responses on the Stressful Life Events Questionnaire was modified to include participants who had experienced both interpersonal and non-interpersonal traumatic life events. Participants in this investigation were therefore more heterogeneous than those in the study by Green et al. which assessed only interpersonal or non-interpersonal traumatic life events, but not those participants who had experienced both.

The population differences between the study undertaken by Green et al. (2000) and this investigation posed further methodological concerns. Compared to Green et al. this investigation included older participants with a mean age of 51 years. In the study by Green et al. none of the 1909 participants

was older than 24 years of age. In this investigation, older participants represented 58% of the total sample and although this might suggest that older people bring with them more life-time opportunities to experience trauma, this is not borne out in the literature on age and trauma (Hatch, 2007; Norris, 1992). Nonetheless, although its relationship with trauma remains unclear at this stage, it is conceivable that age differences might also be a contributing factor to the differences in prevalence rates of trauma between the two studies.

5.2.3 The effect of Traumatic Grief

As dissociation is known to be associated with trauma, this thesis chose to investigate if there is a relationship between dissociation and TG in the bereaved. When the findings of this thesis are taken as a whole, it can be seen that there is an effect of TG on dissociation, because when compared to the Control, the TG+PTSD group showed a significantly greater frequency of dissociation whereas the PTSD group did not. It is suggested that this difference between these two groups is due to the presence of TG. This pattern was not replicated for general psychological distress as both the TG+PTSD group and the PTSD group reported significantly greater general psychological distress than the Control. Therefore, the conclusion of there being an effect of TG on dissociation does not extend to include an effect of TG on general psychological distress.

5.2.4 The effect of traumatic life events

Further to this, when the influence of the number of traumatic events on dissociative frequency and level of general psychological distress in participants was considered, it was found that the three clinical groups were not

significantly different from each other on these variables. Consequently, it was concluded that the TG+PTSD groups' higher frequency of dissociation and higher levels of general psychological distress were unrelated to the number of traumatic life events experienced by these participants. Separate from, but related to this finding is the fact that while there were no group effects for the clinical groups, for the number of traumatic life events, a significant effect was found for the total number of participants. This finding suggests that the number of traumatic life events might have been an influential determinant in the expression of dissociation and general psychological distress, but that one reason for the lack of an effect across groups was due to the constraint of having small sample sizes in the clinical groups.

5.3.0. A psychological construct of traumatic stress reactions

5.3.1 Similarities and differences between Traumatic Grief and PTSD

From the results it is postulated that the conditions of TG and PTSD may be similar but different manifestations of a single construct. The basis for this contention rests on the following similarities and differences:

The TG+PTSD and PTSD groups were similar in that both groups:-

- Showed significantly greater psychological distress that the Control group.
- Showed no significant differences from each other on dissociative frequency or level of general psychological distress.

The TG+PTSD and PTSD groups differed in that:-

- Only the TG+PTSD group showed significantly greater dissociative frequency than the Control. Whereas the PTSD group was not significantly more dissociative than the Control group (raw scores on the Dissociative Experiences Scale show: TG+PTSD>PTSD>Control, underscore indicates significant difference between the groups).

From this pattern of responses, it is proposed that these shared similarities and differences indicate that the two conditions of TG and PTSD are similar but not the same, and possibly even share the same underlying structure that configures all traumatic stress reactions.

It is suggested that the findings of this thesis show that traumatic stress reactions may span a range of responses from which both PTSD and TG stem. Accordingly, this proposition predicts that individuals with a combined presentation of TG and PTSD and those with only PTSD would not significantly differ in their manifestation of frequency of dissociative experiences and level of general psychological distress. As no significant differences were found on these measures between the two clinical groups the data from this investigation supports this prediction.

5.3.2 Implications for intervention

It is clear from the above arguments that there are implications for diagnosis and treatment depending on whether TG and PTSD are conceptualised as being manifestations of the same psychological construct or as different independent phenomena. If it is the case that both conditions arise from a single construct, such as a traumatic stress reaction, specifying a

specific aetiology that leads to these conditions being viewed as unrelated, aids neither diagnosis nor treatment. If they share the same or similar underlying mechanisms, a single-construct perspective enables a deeper understanding of traumatic stress responses where emphasis is placed on the traumatic nature of the symptoms rather than the event that caused them.

5.3.3 Implications for the classification of PTSD

It is argued here that the view taken in the DSM-IV (American Psychiatric Association, 2000) is that PTSD and Criterion A1 trauma are psychological entities independent of other clinical conditions. The data in this study do not support this account and suggest that the present DSM-IV classification may need to consider a combined presentation of symptoms common to PTSD and other traumatic stress related phenomena, such as TG.

In summary, on the basis of the above findings, it is concluded that TG is a syndrome that is associated with a greater frequency of dissociation. It can also be concluded that multiple traumatic life events are a requisite for a greater frequency of dissociation. Finally, it is suggested that TG and PTSD are related syndromes of a single psychological construct, that termed "traumatic stress reaction".

5.4.0 Conclusion

In conclusion, the purpose of this thesis was to investigate in the bereaved, the presence of dissociation in those with TG. From the findings of this thesis, it can be said that dissociation occurs more frequently in the bereaved who meet symptom criteria for both TG and PTSD and less

frequently in the bereaved who do not have either condition. More importantly, the results show that the greater frequency of dissociation in the participants with a combined presentation of TG and PTSD is possibly due to something inherent in the nature of TG itself and is not the result of either PTSD, type of death or relationship with the deceased. It is thus concluded that TG is a unique response to bereavement that is distinct from PTSD. Considering that dissociation and posttraumatic stress symptomatology are significantly correlated, it then follows that TG and PTSD may share the same underlying mechanism.

5.5.0 Future research directions

This thesis demonstrates the need to conduct further research into the relationship between dissociation, TG and PTSD. More specifically, new research needs to be conducted to explore these constructs with reference to traumatic stress responses in order to establish their inter-relationships. Further to this, it is important to clearly establish if dissociation is an aspect of TG because if it is, any treatment developed for TG will need to consider the difficulties with the integration and synthesis of information that accompanies dissociation.

It is further recommended that given the varied approaches to defining dissociation, it is evident that this word is used too broadly to refer to very different aspects of the one construct. It would be of greater benefit if specific expressions of the construct, such as emotional numbing, time distortion, reduced awareness, amnesia or derealisation, were the focus of investigation in

order to better understand the information processing mechanisms that underlie specific dissociative reactions to traumatic experiences. The value in this is that it will provide greater clarity and specificity to each aspect of dissociation under investigation and reduce the indiscriminate inclusiveness that accompanies the term dissociation as it is currently used.

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STRESSFUL LIFE EVENTS SCREENING QUESTIONNAIRE

The questions asked in this survey may be personal and difficult for some participants. They are nevertheless very important in understanding traumatic life events and their impact. I would like to re-emphasise that the information you provide will be treated with the utmost confidentiality.

Should you have any difficulty please feel free to ring the contact number provided on the information sheet or contact one of the counselling services provided on the sheet.

The items listed below refer to events that may have taken place at any point in your entire life, including early childhood. **If an event or ongoing situation occurred more than once, please record all pertinent information about additional events on the last page of this questionnaire.** Please print or write neatly.

1. Have you ever had a life-threatening illness? No _____ Yes _____ If yes what age?

   Duration of illness (in months)

   Describe specific illness

2. Were you ever in a life-threatening accident? ? No _____ Yes _____ If yes what age?

   Describe the accident

   Did anyone die? _____ Who? (relationship to you) _____

   What physical injuries did you receive? _____

   Were you hospitalised overnight? No _____ Yes _____

3. Was physical force or a weapon ever used against you in a robbery or mugging? No

   Yes _____ If yes what age? _____ How many perpetrators? _____

   Describe physical force (e.g. restrained, shoved) or a weapon used against you.

   _____

   _____

   Did anyone die? _____ Who? (relationship to you) _____

   What injuries did you receive? _____

   Was your life in danger? _____

4. Has an immediate family member, romantic partner, or *very close* friend died as a result of accident, homicide or suicide?

   No _____ Yes _____ If yes what age? _____

   How did this person die? _____

   Relationship to this person _____

   In the year before this person died, how often did you see/have contact with him/her?

   _____

5. When you were a child or more recently, did anyone (parent, other family member, romantic partner, stranger or someone else) ever succeed in *physically forcing* you to have intimate sexual contact against your wishes or when you were in some way helpless?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____

If repeated, over what period? 6 mo or less _____

7 mo –2 yrs _____

more than 2 years but less than 5 years _____

5 years or more _____

Who did this? (specify stranger, parent, etc)

_____

Has anyone else ever done this to you? No _____ Yes _____

6. Other than experiences described in item 5, has anyone ever used physical force or threat to TRY to make you have intimate sexual contact, against your wishes or when you were in some way helpless?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____

If repeated, over what period? 6 mo or less _____

7 mo –2 yrs _____

more than 2 years but less than 5 years _____

5 years or more _____

Who did this? (specify stranger, parent, etc)

_____

Has anyone else ever done this to you? No _____ Yes _____

7. When you were a child, did a parent, caregiver or other person ever slap you repeatedly, beat or otherwise attack or harm you?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____

If repeated, over what period? 6 mo or less _____

7 mo –2 yrs _____

more than 2 years but less than 5 years _____

5 years or more _____

Describe force used against you (e.g. fist, belt) _____

Were you ever injured? _____ If yes, describe _____

Who did this ? (relationship to you) _____

Has anyone else ever done this to you? No _____ Yes _____

8. Other than the experiences mentioned in item 7, have you ever been kicked, beaten, slapped around or otherwise physically harmed by a romantic partner, date, sibling, family member, stranger or someone else?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____

If repeated, over what period? 6 mo or less _____

7 mo –2 yrs _____

more than 2 years but less than 5 years _____

5 years or more _____

Describe force used against you (e.g. fist, belt) _____

Were you ever injured? _____ If yes, describe _____

Who did this ? (relationship to you)_____

If sibling, what age was he/she? _____

Has anyone else ever done this to you? No _____ Yes_____

9. Other than the experiences already covered, has anyone ever *threatened* you with a weapon like a knife or gun?

No _____ Yes _____ If yes, at what age? _____

If yes, how many times? 1 _____, 2-4 _____, 5-10 _____

If repeated, over what period? 6 mo or less _____

7 mo –2 yrs _____

more than 2 years but less than 5 years _____

5 years or more _____

Describe nature of threat _____

Who did this ? (relationship to you) _____

Has anyone else ever done this to you? No _____ Yes _____

10. Have you ever been present when another person was killed, seriously injured, or sexually or physically assaulted?

No _____ Yes _____ If yes, at what age? _____

Please describe what you witnessed _____

Was your own life in danger? _____

11. Have you ever been in any other situation where you were seriously injured or your life was in danger (eg. involved in military combat or living in a war zone)?

No _____ Yes _____ If yes, at what age? _____

Please describe _____

12. Have you ever been in any other situation that was extremely frightening or horrifying that has not been covered above?

No _____ Yes _____ If yes, at what age? _____

Please describe _____

13. IF ANY OF THE EVENTS (OR ONGOING SITUATIONS) ALREADY DESCRIBED HAPPENED TO YOU MORE THAN ONCE (e.g., TWO ROBBERIED, TOW DIFFERENT PEOPLE COMMITTING THE SAME ACT) PLEASE USE THE SPACE BELOW TO DESCRIBE EACH ADDITIONAL EVENT OR ONGOING SITUATION. PLEASE PROVIDE ALL INFORAMITON REQUESTED UNDER THE ORIGINAL ITEM.

Item Number _____ Description _____

_____

_____

_____

Item Number _____ Description _____

_____

_____

_____

Item Number _____ Description _____

_____

_____

_____

14. AS YOU FILLED OUT THIS QUESTIONNAIRE, DID YOU REPORT THE SAME INCIDENT OR ONGOING SITUATION UNDER MORE THAN ONE ITEM?

No _____ Yes _____

If yes please indicate which items refer to the same incident.

_____

_____

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3. Blacken the circle for either male or female.
4. If you want to change a response, erase it carefully and then fill in your new choice.
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Please circle you responses

1. Please specify your sex: Male/Female

2. What is your marital status? Never Married / Separated / Divorced / Married / De facto / Widowed

3. What is your age bracket? 18-29 / 30-39 / 40-49 / 50-59 / 60 -69 / 70-79 / over 80

4. What is the highest level of education you have completed?

   a) Primary School
   b) High School Year 10
   c) High School Year 12
   d) TAFE
   e) University Undergraduate
   f) University Post Graduate

5. What is your annual income:

   a) Less than $20,000
   b) $20,000 - $30,000
   c) $31,000 - $40,000
   d) $41,000 - $50,000
   e) $51,000 - $60,000
   f) $61,000-$70,000
   g) $71,000 - $80,000
   h) $81,000 - $90,000
   i) Above $90,000

6. What is the postcode of your home address?

7. Has anyone very close to you died? YES / NO (if no please go to Question 8)

   a) What is the length of time since this death? _____
   b) What was the nature of your relationship with the deceased?
      Daughter / Son / Husband / Wife / Mother / Father / Sister / Brother / Friend
   c) Other (please specify) _____
   d) Has this had an adverse effect on you? YES / NO

8. How many sessions have you had with a counsellor, psychologist or psychiatrist relating to your grief?

   a) None b) One to two c) Three to five d) Six to ten e) More than ten

9. Have other people close to you died? YES / NO (if no please go to Question 9)

   a) What is the length of time since this/these deaths? _____
   b) What was the nature of your relationship with the deceased?
      Daughter / Son / Husband / Wife / Mother / Father / Sister / Brother/ Friend
   c) Other (please specify) _____
   d) Has this had an adverse effect on you? YES / NO

10. How do you feel you are coping with life currently?
    Well / Average / Struggling / Not coping at all

School of Psychology

General Information Sheet

Thank you for offering to participate. This study is being conducted as part of a Master of Clinical Psychology degree. The purpose of the study is to understand the effects of grief, as experienced through bereavement, in order to be better able to assist those who might need assistance through early identification of traumatic grief. Grief is frequently thought of as a process that will heal with time but this is not the case for all and for those, whose grief is slow to heal, perhaps if it is better recognised assistance could be provided at an earlier stage. Whether your grief is simple and straightforward or whether it is more complex this study will benefit from your participation. For this reason your honesty in answering the questions is of importance.

What you will be asked to do

Participants are asked to complete 5 questionnaires and a general personal information sheet. The questionnaires are self administered and it is expected that this will take approximately one hour of your time but for some this may lengthen to two hours as they may require more time to think through their answers. The information gained from your own personal experiences will go towards gaining a greater understanding of the grief and bereavement process. Some of the questions may be difficult and you may find them overwhelming or possibly even offensive. All questions asked have had great consideration and deliberation and as far as possible, without compromising the study, questions have been modified so as to minimise the chance of offence. Details of counselling services area provided should you need to access any of these.

Confidentiality and consent

All information provided by you will be treated with the utmost confidentiality. In fact the only time we keep your name and address is on your consent form . The information on your consent form will not be linked to your responses on the questionnaires. All information obtained will be kept secure with access by authorised individuals only. Information provided by you will be destroyed after 5 years.

Withdrawal from the study

If at any stage you wish to withdraw from the study you are free to do so at anytime without prejudice. However, once you have sent in your questionnaires retrieval of your information will not be possible as there will be no means by which to identify you.

Counselling Agencies

If you should need to access a counselling service some of these community agencies may be able to help.

General Counselling Services - Hobart

Anglicare, 18 Watchorn St., Hobart Tel 03 6234 3510

Centacare. 23 Stoke St., New Town Tel:6278 1660

Lifeline 24 hour telephone counselling service, Tel 131 114

Grief and Bereavement Counselling Services - Hobart

Grief Counselling Service, Royal Hobart Hospital Tel: 6222 8308 – free service

General Counselling Services - Sydney

Anglicare Counselling, Ashfield Office 56 Bland St., Tel:02- 9799 9311

Anglicare Counselling, Penrith Office 161 Derby St., Tel 02-4731 6467

Anglicare Counselling, Wollongong Office 152 Keira St., Tel: 02- 4228 9612

Centacare Blacktown 51 Allawah St., Tel: 02 9671 2011

Centacare Naremburn Family Services 40 Merrenburn Ave Naremburn, Tel: 02 8425 8700

Centacare Northern Region 20 George St., Hornsby. Tel: 02 9476 8433

Lifeline 24 hour telephone counselling service, Tel 131 114

Grief and Bereavement Counselling Services - Sydney

Bereavement Service at the Manly Community Centre Tel: 9977 1066 -free service

Bereavement Care Centre, 14 Hollis Avenue, Eastwood Tel: 1300 654 556.

Grief Support 02-9489-6644 (a 24 hour telephone counselling service) – free service

General Counselling Services - Melbourne

Anglicare Victoria, 5 Frith St., Brunswick 03-9387 5890

Centacare, 383 Albert St., East Melbourne 03- 9287 5555

Lifeline 24 hour telephone counselling service, Tel 131 114

Grief and Bereavement Counselling Services - Melbourne

Bereavement Counselling Service, 321 Glenferrie Road, Malvern, Melbourne - free service

Griefline 03-9596 7799 from 12 noon – 3 a.m. (a 15 hour telephone counselling service) - free service

Approval

This project has received approval from the Southern Tasmania Social Sciences Human Research Ethics Committee. If you have any concerns of an ethical nature or complaints about the manner in which the project is conducted please contact the Chair or Executive Officer of the Southern Tasmania Social Sciences Human Research Ethics Committee.

Chair:- Associate Professor Margaret Otlowski (03- 6226-7569)

Executive Officer: Amanda McAully (03-6226-2763)

Thank you for your assistance in this study. Your help is greatly appreciated

Private Bag 30
Hobart
Tasmania Australia 7001
Telephone (03) 6223 4563
Facsimile (03) 6226 2883
Email: lum@utas.edu.au